State

Registrar

APR 2 8 2004

		1 - For Amend Item #8 per Registrar	State of Marylo	and / Depa 4 tas <i>Cer</i>	artment of H	lealth and N Death	lental Hy	giene 200	15503
Physici /Medic	cal	1. Decedent's Name (First, Middle, Last)  MILDRED  4a. Fecility Name (If not institution, give s	TURN			Location of Death	2. Date of De Month 04-		4 13 40M
Funeral Director	ier	SOUTHERN MARY	AND HOSPIT	TAL (EVIGA rs. last birthday) 71 Yrs.		INTON If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	PRINC th <b>5/10/1923</b> 9, Bi	E GEORGES inthplace (State or Foreign Country) LABAMA
ס	ctor	Usual Residence of Decedent 10a. State 10b. County DC	10c.	City, Town or Lo		J		,	10d. Inside City Limits XX Yes 2 □ No
ING 21215-UU36 be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23e or 28e-1 show event, tre Medical Examiner must be notified at	/ Funeral Director	1 Never Married 2 Married	VE. NE #308  12. Was Decedent Ever in Armed Forces?  1	า U.S. 13. V	10f. Zip Code	0019 ispanic Origin? (Spin, Mexican, Puerto	ecify Yes or No Rican, etc.)	UNITED ST 14. Race - Am Black, Wh  Specify: B	ATES encan Indian, ite, etc.
Z1Z1	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2 TH	Year or Dates: cation completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done of OO NOT use retired CHEF	during most of work		16b. Kind of Busines	
arylca should and Mer a marke aumatic	To Be	17. Father's Name (First, Middle, Last)  John Wesley Hall  19a. Informant's Name/Relationship (Ty.  Nelson Turner/son	oe, Print)			Peo and Number or Rui	ola Lit al Route Numb	er, City or Town, State,	Zip Code)
IMOFE, Pages 1 an nent of Heal ent: If item 2 ury or other		20a. Method of Disposition  1½ Burial 2 □ Cremation 3 □ R  14 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo- cemetery, cren ashingto	sition (Name of natory or other place on Nat 1	θ) 4-30-	Date - 2004	20746 20c. Location - City o	Maryland
Baltim permit. Pac Department Importent: any injury c		21. Signatuje of Funeral Service License  22. Parl 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the d	MIC 43	08 Suitl	and Road	Suitlar	s Funeral H nd, Marylan rrest,	
P ( D )  Tate be executed  The purial-transit the burial-transit the b	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a constitution for the to (or a)).	sequence of):  Ry  sequence of):  NCED	RACT RHEW	INF		N	Onset and Death
death certific	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1  Live birth 2  F 4  Pregnant at time of	gnancy etal death 3	Ectopic pregnancy			23d. Date of do Month	elivery Day Year
cords, F.O. w requires that the been signed by th should be detache	þ	Part II. Other significent conditions cor	itributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute	to the cause of death? Probably 4 Denknown
	e Completed	ANEMIA DIABETES  25. Was case referred to medical	MELLI	rvs		26. Place of Deat	1 Tes	ormed? death? 2 ☑ No 1 ☐ Ye	autopsy findings available completion of cause of
ISION OT VITA  ttending Physician: death. ctor: After this cartifica  t the funeral director, I	ToB	examiner?  1 Yes 25 No F  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injun Worl	er: 4 🗆 Nursing Ho	me 5□Resi	dence 6 Other (Sp how injury occurred	ecify)
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After	i Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Specialist To the best of the	ecify)		an data and plan-	City or To		
To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai		sician: To the best of my ner: On the basis of exam and manner stated.	ination and/or inv	restigation, in my o	pinion, death occur e number	red at the time,	date and place, and du 29d. Date signed (Mon	e to the cause(s)  oth, Dey, Year)
e (4)		30. Name and address of person who co		) ING PHY Item 23a) (Type, 1 8700	Print) CENTRA	D 00 > 20	301 L	ANDOVER	MD 20785
Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 7 2004	32. Registrar's Si	gnature	w .		,		-

			For State Registrar	State o	f Marylar	nd / Depa <i>Ce</i>	artment of rtificate o	Health	and M h	lental Hyg	iene 20	104	15504
0			Decedent's Name (First, Middle,	Last)						2. Date of Deat	h	Year	3. Time of Death
	Physici /Medic		Louise B. Taylor							April		Year )4	7:55 A M
	Examin		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, Town	n, or Locatio	n of Death		4c. County		
	12		Wicomico Nursing Ho 5. Social Security Number		7. Age (In yrs.	last hirthday)	Sal If Under 1 Ye	isbury ar lifUnd	er 24 Hrs.	8. Date of Birth	W	/icomi	
	Funeral Director		219–36–5789	1 □ M 2 🔀 F	94	Yrs.	Months Da		Min.	(Month, Day, September	Year) 27,1909		place (State or Foreign htry) vland
			Usual Residence of Decedent							repositor	21/1203		
	irytan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	10d. Inside City Limits 1 ☐ Yes 2X No
	8a-f s	octo	Maryland Wicomi	.co	Wi	llards					0-02		
	with ti	듬	10e. Street and Number	City Boo	a		10f. Zip Cod 218			'	0g. Citizen of V	USA	ntry ?
	ne 23	Funeral Director	36018 Old Ocean	12, Was Dece	edent Ever in U	l.S. 13.	Was Decedent	of Hispanic (	Origin? (Spi	ecify Yes or No-	14. Race		can Indian,
30	d within 72 hours after death with the Maryland jiene. I than "naturel", or Iteme 23a or 28a-f show the Medical Examiner must be molified at	by Fun	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	If Yes, Giv	2 <b>K</b> ) No /e		lfYes, specify C 1 □ Yes 2 😾 I	uban, Mexic	an, Puerto	Rican, etc.)	Specify	k, White, יי זאל	etc. nite
9500-6121	hour:	q pa	15. Decedent's	Year or D	ates:	16a Dece	dent's Usual Oc	cunation		- 1	16b. Kind of Bu		
<u>က</u>	within 72 ene. than "nal	Completed	(Specify only highest	grade completed)	Ang E s \	(Give	kind of work do DO NOT use re	ne durina m	ost of work		100. 11110 01 00	201110000111	
212	filed with Hygiene. ither than	E O	Elementary/Secondary (0-12)	College (1		Teach	er				Educat	ion	
and		Be C	17. Father's Name (First, Middle, L.						_	e (First, Middle, I	_	•	
		To	James Frank		Brittir				nnie		Ray		
Mary	and and mum		19a, Informant's Name/Relationshi							Al Route Number			843
	f Health Item 27 other tr		Dean Richardson 20a. Method of Disposition	n (CO	usin)		osition (Name of			City, M	ar yranc 20c. Location -		
Baitimore,	0 0		1X Burial 2 Cremation		State	cemetery, cre	matory`or other	olace)					
			<ul> <li>4 □ Donation 5 □ Other (Special Signature of Fungral Service Line)</li> </ul>		∣ D∈	2	Cemetery  2. Name and Ad	dress of Fac	vility	- 17-37-31-			, Maryland
g	permit. Depart Import any inj		> Will of	Alm.no.	CES	م F	Iolloway	Fune	ral He	ome Prof , Salisb	essiona	al As	sociation nd 21804
3/60,	death certificate be executed  e attending physicien and do for use as the burial-fransit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, framework to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	or as a consec	quence of):			1045	e AR			
Õ	rtificate ng phys as the	Medi	IF FEMALE:								2017		
O. Box	at the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□No 9 □ Unknown		ointh 2 ☐ Feta nant at time of c	uldeath 3[	□Ectopic pregna □ Other (specify				23d. Dat Mor	e of delive	ery Day Year
٦.	The law requires that the tile has been signed by this bage 2 should be detache	by Ph	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying cause	given in Pai	n I.	23e. Did tob	acco use contr	ribute to th	ne cause of death?
202	w require been sig should b									1 □ Y€	s 2 No	3 🗌 Prob	ably 4 Unknown
ပ္တ	e law re has bee	Completed								24a. Was a autops	n 24b. V	Nere auto	psy findings available mpletion of cause of
ř		mo.								perform	hed?   c	leath?	
Vital Records,	iclen: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	71				The Party of	ce of Death	n (Check only on	θ)		
0	Physicle this cert al direct	ပ္	1 Yes 25 No		Inpatient 2		IL 3 DOA		-	me 5 Reside			y)
	ding P. After funera	lo I	27. Manner of Death  1 ■ Natural 5 □ Pending		th, Day Year)	28b. Time o Injury	1	njury at Work? I □ Yes 2 I		28d. Describe ho	w injury occurr	ed	
Division	deat deat stor:	Certification:	2 Accident investige 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - At h	ome, farm, st	reet, factory, offi			28f. Location (St City or Town	reet and Numb n, State)	er or Rura	I Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by		29a. Centify 1 Certifying	Physician: To the	hest of my kn	nwledne deat	b occurred at the	e time date	and place	and due to the ca	use(s) and ma	nner as si	tated
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical		xaminer: On the b									
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Lic	ense numbe	ır	2	9d. Date signed	(Month,	Day, Year)
•	0		The John				DC	JOOG		1	APRIC	19, 3	2004
1	int		30. Name and address of person w				Print)						
				4 Easterns			sbury, MD	21804					
	Sta Regista		31. Date filed (Month, Day Year) APR 2	2 2004 32. 8	legistrar's Sign	ature	9 10	als	•				

	•	For State Registrar	State of Maryl		tificate of			10g. No. 2004	1550
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
Physici /Media		PATR	ICK WOOLRII	OGE				19 2004	2:45 A N
Examir	_	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County of Death	l.
		NATIONAL NAVAL N			B If Under 1 Yea	ETHESDA r If Under 24 Hrs.	O Date of Birth	MONTGO	
uneral irector		5. Social Security Number 6. Sec. \$2.50	7. Age (In	yrs. last birthday) 65 Yrs.	Months Days		8. Date of Birth (Month, Dey MAR . 14	, 1939 WASH	place (Stete or Foreig intry) INGTON, DO
* 22		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limit
s tow	ō	DC				NT.			XXYes 2□N
288- DOM	Director	10e. Street and Number		W	ASHINGTO 10f. Zip Code	<u>IN</u>		10g. Citizen of What Cou	intry?
33 0	al D	1438 T ST. SOUT	HEAST		2	0020		UNITED STAT	ES
i i	Funeral		12. Was Decedent Ever Armed Forces?	in U.S. 13.		Hispanic Origin? (S) ban, Mexican, Puert			ican Indian,
al', or ite Examina	b	1 ☐ Never Married 2 ☐ Married  XXWidowed 4 ☐ Divorced	XXYes 2 ☐ No ] If Yes, Give	1974-	1⊡Yes XXX		, , , , , , ,	Specify: BLA	
item 27 ie marked other than "natural", or Iteme 23e or 28e-1 shov other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of work	king	16b. Kind of Business/li	ndustry
ie marked other than aumatic event, the M	E O	12TH	College (1-401 5+)	S'	TOCK CLE	RK		NAVY	
l other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
arkec atic e	2	RAYMOND D. WOOLRII	DGE			1	E FLANNI		
raum raum		19a. Informant's Name/Relationship (Ty			•			r, City or Town, State, Zi	
em 27 ther t		HARRIETT SIMS (SI		1438 Db. Place of Dispo		OUTHEAST		GTON, DC 20 20c. Location - City or T	
		XX Burial XXCremation 3 □F	Removal from State	cemetery, crei	natory or other pl				
Important: If item 27 any injury or other tr once		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service (doesn's		25	Name and Add	MATORY 23		ALEXANDRIA	
Important: If any injury or			lareshol	() M	ARSHALL'	S FUNERAL LAND ROAD	HOME OF	MARYLAND, I ND, MD 2074	NC.
11 (		23a. Part 1. Enter the disease, or compleshock, in eart failure. List only of	ications that caused the one cause on each line.	dea Do not ent	er the mode of dy	ring, such as cardiac			Approximate Interval Between
sician	П	Immediate deuse (Final disease or condition	METAST	ATIC PRO	STATE C	ANCER			Onset and Death
dical niner		resulting in death)	Due to (or as a cor		COLLEGE CO.	31,001213			
IIII	_	Sequentially list conditions,	Due to (or as a nor	entrane di					
ısit	ulue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dae to (or as a tio)	говирантов эту.					
ysician and ie burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
e buri	calE		1						
attending physical for use as the t	by Physician/Medi								
r use	an/h	230. Was decedent pregnant	3c. If yes, outcome of pro		Ectopic pregnan	су		23d. Date of deliv	
detached for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)			Month	Day Year
ietach	Phy	Part II. Other significant conditions con	stributing to death but no	t reculting in the u	nderlying cause o	twee in Part I	23e Did to	bacco use contribute to	the cause of death?
9		Tall II. Otto organioan conditions con	minustrig to doubt bettie	Crossiang in the d	ndenying cause g	IVOIT WIT CITET.			babiy 4 🗆 Unknow
should	ete						24a. Was a	24h Worn 2ut	ancy findings availab
9 2	Completed						autops	mad?   death?	opsy findings available ompletion of cause of
or, pa		25. Was case referred to medical				OC Place of Dec			2 No
is certificate director, pag	To Be	examiner?	Hospital:	2 ER/Outpatier	it 3 DOA	Phor	th (Check only or	ence 6 Other (Speci	iful
eral o	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	-	COLUMN TO THE PARTY OF THE PART		ow injury occurred	97
r: Atter e funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day 198	r) Injury		ork? □Yes 2□No			
by th	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office	9	28f. Location (S City or Town	treet and Number or Rui n, State)	al Route Number,
illed ir	Cel		1						
To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification;		sician: To the best of my ner: On the basis of exa- and manner stated.						
To the	Me	29b. Signature and title of certifier	)		29c. Licer	nse number	2	29d. Date signed (Month,	Dey, Year)
		1/1/aute	busions	- Wr	0101	235480 (V.	A)	4/19/	2004
		30. Name and address of person who co	phpleted cause of death	(Item 23a) (Type,		NA	TIONAL N	AVAL MEDICA	
M									
9		MARK N. DAMIANO  31 Date filed (Month, Day, Year)	LT MC USI			BE	THESDA M	ID 20889-560	00

CA	2
	State Registrar
DH	MH 17 Rev 1/2001

		Please Type State Registrar AMEND ITEM #5	ate of Ma	ryland /	Depa	rtment of H	ealth and	_		e 2nn	
Physici		1. Decedent's Name (First, Middle, Last)	shingto			inouto or E		2. Date o	f Death	ay Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give street		711		4b. City, Town, or	Location of Deal	04		9 2004 lc. County of Dea	
Examin	ier										
		Fort Washington Hosp  5. Social Security Number 6. Sex		(In yrs. last b	irthday)	If Under 1 Year	shingto If Under 24 Hrs		f Birth n, Day, Yea	Prince G	
Funeral Director				7	Yrs.	Months Days	Hours Min.		04 19		nthplace (State or Foreign country) N.C. herfordton.
		Usual Residence of Decedent						1 09	04 13	ZO KUL	merroraron,
yland		10a, State 10b. County		10c. City, Tov	wn or Loc	cation					10d. Inside City Limits
Mar Mied	ţ	D.C.		Wash:	ingt	on					1x∑Yes 2 No
r 28	Director	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What C	Country?
1 wit	aiD	2223 13th. Street N	I.E.			20018				USA	
deat	Funeral	11. Marital Status 12. W	as Decedent Evened Forces?	ver in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	Specify Yes o	r No-	14. Race - Am Black, Wh	
or Ite	F	1 Never Married 2 Married 1	☐ Yes 2 🔯 No Yes, Give	0		☐ Yes 25kNo	Specify:		.,	Specify: B1	
ours Exp.	d by	3 🛣 Widowed 4 □ Divorced Ÿ	ear or Dates:			24.00				Specify. 151	
72 h	Completed	15. Decedent's Education (Specify only highest grade com		16	(Give I	lent's Usual Occupa kind of work done of	turing most of wo	orking	16b.	Kind of Busines	s/Industry
of thin	idu		ollege (1-4or 5+			OO NOT use retired				a 14.1	1
led w lygier her ti		5th.		B	satte	ry Fille	18. Mother's Na		_	Cone Mil	.1
be find of the state of the sta	Be	17. Father's Name (First, Middle, Last)						Forne		en Sumame)	
Mer Marke Marke	2	Garfield Neighbors				111				T 0	T. O. (1)
l 2 sh and r is m		19a. Informant's Name/Relationship (Type, P.				g Address (Street a					
and fealth m 27 her t		Savannah Neighbors	Daught			13th. St	. N.E. W	Vashing Date		D.C. 20 Location - City of	
Fof F		20a. Method of Disposition  ↑Surial 2 ☐ Cremation 3 ☐ Remov	al from State	cemet	ery, crem	natory or other plac				Location - City o	rown, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: it Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, I'm Madical Explainted at ance.		* 4 □ Donation 5 □ Other (Specify)		Piney		ge Cemete		6-2004		on Mill	
permit Depart Impor any in		21. Signature of Funeral Service Licensee	.00		1	. Name and Addres					
g ⊡ = @ d		Maish				217 9th.				on, D.C.	
		23a. Party Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused t use on each line	the death. Do e.	o not ente	er the mode of dyin	g, such as cardia	c or respirato	ory arrest,		Approximate Interval Between Onset and Death
Physician			rterios	sclerot	ic (	Cardiovas	cular Di	isease			6 vrs.
/Medical		resulting in death)	Due to (or as a	consequence	e of):						
Examiner		Sequentially list conditions, b. D	iabetes								6 yrs.
₽ #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	s consequence	e of):						
be executed sician and burial-transit	me	Cause (Disease or injury that initiated events c	2 11 /		0						
be exe	al Ex	resulting in death, cast	Due to (or as a	a consequence	e or):						
ate b hysic the b		d									
death certificate l attending physi I for use as the t	by Physician/Medic	IF FEMALE:		,escat							
ath c	lan/	in the past 12 months?	yes, outcome of □Live birth 2	2 ☐ Fetal deal		Ectopic pregnancy				23d. Date of d Month	elivery Day Year
e de the a	Sic	1 Ves 2 No	□Pregnant at t □Unknown	time of death	5 🗀	Other (specify)					
uires that the dei signed by the a Id be detached to	Ph	Part II. Other significant conditions contribut	ting to death but	it not resulting	in the ur	adarhina causa anu	an in Part I	230	Did tobacc	o use contribute	to the cause of death?
rest signe			-								Probably 4 Unknown
w require been sig	ted	Hypertension							<del>-</del>		
law lasb	Completed								Was an autopsy	prior to	autopsy findings available completion of cause of
The aate h	Son								performéd es 2020		
sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check o	only one)		
hysi this c	2	1 ☐ Yes 2 ☑ No Hospit	1 & inpatier	nt 2 ER/C			4   Nursing			6 □Other (Sp	ecify)
Ing P	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	la. Date of Injury (Month, Day	Year) 28b	. Time of Injury	Wor		28d. Desc	ribe how in	jury occurred	
eath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □ No				
r At ter d lrect	Certification:	3 Suicide 6 Could not be determined 28	le. Place of Inju building, etc.	iry - At home, (Specify)	farm, str	eet, factory, office		28f. Locat City o	ion (Street ir Town, St	and Number or I ate)	Rural Route Number,
rel D											
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effer death. To the Funerel Director: Affer this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1⊠ Certifying Physician (Check only 2 Medical Examiner: (	On the basis of	examination a	lge, death and/or inv	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to curred at the t	the cause ime, date a	(s) and manner a and place, and di	as stated. ue to the cause(s)
thin 2	Med	29b. Signature and title of certifle	and manner stat			29c. Licens	e number		29d. I	Date signed (Moi	oth Day Year)
T CO		200. Signature and and or certifier	2/10	11						pril 22	
(0)		1///	1-12	//N		D-58	330	·		22	
(2)		30. Name and address of person who comple						_		017	
	Ļ	Jerry F. Myers, M. J 31. Date filed (Month, Day, Year)	32 Bacistra	0 Varni	um S	t. N.E. V	<i>lashingte</i>	on, D.	C. 20	01/	
St Regist	ate	APR 2 7 2004	32. Registra	a digitature	house	E)					
ricgist	ıraı	APR & 1 LUUT		- 7							

James 04-027		w:	nston, II	Plea	ase Type or Pr State of N			nk. Ensure A			
RJ			1 - Stata Registrar			,	Certificate of			eg. No. 2001	15507
	Disconini.		1. Decedent's Name	e (First, Mida	lie, Last)				2. Date of Deat Month	Day Year	3. Time of Death
	Physicia /Medic		JAMES		EDWARD		NSTON, I		April 2		0128 P. M
E.	Examin	er	4a. Fecility Name (# Suburban		on, give street and numbe -a1	or)		m, or Location of Death :hesda		4c. County of Dea	nery County
	Firmanal		5. Social Security N			Age (In yrs. last bii	rthday) If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birth (Month, Day,		inthplace (State or Foreign Country)
	Funeral Director		577-15-0		6. Sex 7. / F□ M 2□ F	23	Yrs. Months Da	ays Hours Min.	10-21-	1980 WA	ASH., DC
	pu *		Usual Residence of 10a, State	Decedent 10b, Count	v	10c. City, Tow	n or Location				10d. Inside City Limits
	ith the Marylar or 28e-f ehow	ō	MD		CE GEORGES	,	NBELT				1 X Yes 2 ☐ No
	28e	rect	10e. Street and Nur		CE GEORGES	S GREE	10f. Zip Cod	de	1	0g. Citizen of What C	Country?
	h with	Funeral Director	9176	SPRIN	G HILL LAN	ΝE		20770		U.S.A	Α.
	ems (	iner	11. Marital Status		12. Was Deceder Armed Force rried 1 ☐ Yes 22	nt Ever in U.S. §?	13. Was Decedent If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No- c Rican, etc.)	14. Race - Am Black, Wh	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28e-f ehow other treumatic event, the Wedical Examinations in	by	1 🛣 Never Marri 3 🗆 Widowed		If Yes Give		1 □ Yes 2 <b>X</b> □	No Specify:		Specify:	BLACK
Maryland 21215-0036	within 72 hc ene. then "natur	Completed	(Spec	cify only high	ent's Education est grade completed) College (1-4c		Decedent's Usual O (Give kind of work di life. DO NOT use re	one during most of won	king	16b. Kind of Busines	s/industry
212	d with	Com	Elementary/36co	indary (O-12)	2		EXECUTIV	E SOUS. C		CHEF GEO	OFF'S
P	be file tal Hy d oth	Be	17. Father's Name	(First, Middle		IIINOM	ON T		ne <i>(Fir</i> st, Middle, I		CH
Z Ja	12 should be filed within had Mental Hygiene. 7 Is marked other then "treumatic event, the Mental Hygiene"	ဥ	JAMES  19a. Informant's Na	omo/Bolation	EDWARD	WINST		MICHE		WIMB ]	
	and 2 shealth and 27 ls r				USAR - SIS	STER	9176 SPR	ING HILL	LANE, G	REENBELT	r, MD 20770
Baltimore,	ges 1 a		20a. Method of Disp		a 3 □Removal from Sta	te cemete	of Disposition (Name of ary, crematory or other	r place)		20c. Location - City of	
草	permit. Pages to Department of Filmportent: If ite any injury or ot once.		`4 □Donation  21. Signature of Fu		-	HARMO	NY MEMOR	AL + 4-28 ddress of Facility $TA$			, MARYLAND
Bal	permi Depa Impo any ir		21. Signature of Fu	interal Service		\					.DC 20001
			23a. Part1. Enter t	he disease,	or complications that caus	sed the death. Do					Approximate Interval Between
	Pnysician		Immediate Cause disease or condition	(Final	st only one calue on each	(a)-e	Nucie	S			Onset and Death
	/Medical Examiner		resulting in death)		a. Due to (or	as consequence	ons				
	LAGITIFIC	<u>_</u>	Sequentially list co	nditions,	b. — Due to (or	as a consequence	of):				
_	uted d ansit	Examiner	cause. Enter Under Cause (Disease or that initiated events	eriying	4						
o,	execut an and rial-tran		resulting in death)	Last	Due to (or	as a consequence	of):				
Box 68760,	rificate be executed g physician and as the burial-transit	licai			d.						
9 ×	ertifica ding pl	Med	IF FEMALE:		23c. If yes, outcor	me of pregnancy				and Date of d	lalis sans
Bo	eath cert attendin for use	cian	23b. Was deceden	months?	1 ☐ Live birth	2 ☐ Fetal death t at time of death	h 3 Ectopic pregr 5 Other (specif			23d. Date of d Month	Day Year
P.O.	that the di ed by the detached	hysi	1 ☐ Yes 2 ( 9 ☐ Unknown		9□ Unknowr						
	88 60	d by Physician/Medicai	Part II. Other signi	ficant condi	tions contributing to deat	h but not resulting	in the underlying caus	e given in Part I.			to the cause of death?  Probably 4 💆 Unknown
00	w requir	lete							24a. Was a	ın 24b. Were	autopsy findings available o completion of cause of
of Vital Records,	The lavate has	Completed							autops perfor 1 Yes	med? death? 2 □ No 1 X Ye	es 2 No
<u>=</u>	icier: T certificat recto, p	Bec	25. Was case reference	rred to medic		-			ath (Check only or		
of \	Physicier: this certific ral directo,	은	1X Yes 2 27. Manner of Dea		Hospital: 1 Inp		utpatient 3 DOA Time of 28c.			ence 6 Other (Sp ow injury occurred	pecify)
on	ding F h. After funer	Certification:	1 Natural 2 Accident	5 Pend	28a. Date of I ding (Month, stigation	Day Year)	Juliury 30 PM	Injury at Work? 1 Tyes 2 No	driver	of a m	b at tree
Division	Attendia or death. octor: A by the fu	ifica	3 Suicide	6 Coul	d not be 28e. Place of	Injury - At lome, ( , etc. <i>(Specify)</i>	arm, street, factory, of	ffice	28f. Location (S City or Tow	treet and Number or I State)	Rural Route Number,
Ö	tel or Att	Cert	4   Hollicide		ballang	, etc. (Specify)	street		EBLOC	restoring	Francis Control
	Hospi 4 hour Funer ely fill	dicai	29a. Certifier (Check only	1 Certify 2 Medic	ring Physician: To the be al Examiner: On the basi	s of examination a	ge, death occurred at t ind/or investigation, in	he time, date and place my opinion, death occu	), and due to the c irred at the time, d	ause(s) and manner late and place, and d	a tated. ue to the cause(s)
	To the Hospitel c within 24 hours at To the Funerel D completely filled in	Med	29b. Signature and	d title of earti	and manner	stated.	29c. L	icense number	2	29d. Date signed (Mo	nth, Day, Year)
	To With		Att.		1 2 · - te	JO2	·mo	.C.M.E.		April 23,	2004
c.D	(2)		30 Name and add	lress of perso	on who completed cause	of alenth (Item 23a)	(Type, Print) 111	Penn Stree	t, Balti	more, Mar	yland 21201
UK	- 3/		PATRI	CIA	ATONICA.	FOLLAK	MD				
	St Regist	ate trar	31. Date filed (Mor	nth, Day, Yea		istrar's Signature	book				

Registrar

APR 2 6 2004

		1 - State Registrar	State of Maryla	and / Depa <i>Ce</i>	artment of H	lealth ar <i>Death</i>		iene200	14 15509
		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
Physici		REGINALD	Т.	WIN	GATE		APRIL	16 20	004 11:15A M
/Medi Examir		4a. Facility Name (If not institution, give si	treet and number)		4b. Cily, Town, o	r Location of I	Death	4c. County of	Death
		7387 CANAL STREE	T		WILLAR	EDS .		WICO	MICO
Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min (Month Day	Year	Birthplace (State or Foreign Country)
Director		218-24-4329	M 2□F 7	4 Yrs.			NOV. 13	, 1929	MARYLAND
pu &		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
aryla sho	5	MARYLAND WICOMICO		WILLA					1∭Yes 2 No
the M 28a-f	Director	10e. Street and Number		WIDDI	10f. Zip Code		1	0g. Citizen of Wh	nat Country?
with with			·m		21874			USA	,
eath	era		2. Was Decedent Ever in	U.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)	14. Race -	American Indian,
Ind 21215-0036  be filed within 72 hours after death with the Maryland tall Hygiene.  id other than "natural", or items 23e or 28e-f show event. Ite Medical Exercises must be natified at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ZiYes 2 □ No If Yes, Give Year or Dates: 194		If Yes, specify Cuba 1 ☐ Yes 2 No		Puèrto Rican, etc.)	Black, Specify:	White, etc. WHITE
Pour Pour		15. Decedent's Educ			dent's Usual Occup	ation		16b. Kind of Busi	ness/industry
15 in 72 an' r	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most o	of working		,
with lene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		CIVIL E	ENGINEE	ER	PARTS M	ANUFACTURING
d 2 filled Hygir other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle, I	Maiden Sumame)	
Maryland 21215-0036 d 2 should be filed within 72 hours aff the and Montal Hygiens 18 18 marked other then "natural", or traumatic event, the Modical Exercitivations.	To B	REGINALD H.	WING			ALI		HOWARD	7- O-4-1
Mar 12 sh and 7 Is n		19a. Informant's Name/Relationship (Type DEBBIE TOWNSEND/DA					or Rural Route Number ALISBURY, N		are, zip Codej
C = '' -	1 9	20a. Method of Disposition		o. Place of Dispo					ity or Town, State
00		1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or other plac				
Baltimore, bermit. Pages 1 a Department of Her mportant: If item iny injury or othe		'4 □ Donation 5 □ Other (Specify)  21. Signature of Fulliperal Service License			CEMETERY  2. Name and Addre	- 200	20/04	WILLAKUS	, MARYLAND
Baltimo		1 Carles W	2 ml	HA	STINGS F	UNERAL	HOME, SELB		DE. 19975
		23a. Part   Enter the disease, or complice shock, or heart failure. List only on	eations that caused the de e cause on each line.	eath. Do not en	ter the mode of dyin	ng, such as ca	ardiac or respiratory arr	est,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	TOUG	Dath	ric Pu	Umo	nant Fi	MOSI:	S Offiser and Death
/Medical		resulting in death)	Lue to (or as a cons	sequence of):		2	01	l.	
Examiner		Sequentially list conditions, b	Chronic	ab5	muchy	CH	ulmona	ry elis	ease
p ti	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cons		0. 20.	)			
ecute and -trans	Examin	that initiated events c.	Due to (or as a cons	10.71	uper	the s	IN.		
8760, ate be executed hysician and the burial-transit			D0010 (01 43 4 0011	Company					
8760, cate be e	dicai	<b>↓</b> d	•					-	
. Box 68760, death certificate be executed eathending physician and defor use as the burial-transitions.	Physician/Me	IF FEMALE:	3c. If yes, outcome of pre	gnancy				23d. Date	of dolivery
Box eath cert attendin for use	ian	in the past 12 months?	1 Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic p <b>r</b> egnancy □ Other <i>(specify)</i>	/		Month	
O he de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ordeath of					
P.O.	Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did tot	pacco use contrib	ute to the cause of death?
ds,	d by						1 □ Ye	s 2 □ No 3	Probably 4 Unknown
cord  * require been si	eted						24a. Was a	n 24h We	ere autopsy findings available
I Records, P.O. The law requires that the rate been signed by the page 2 should be detached.	Comple						autops perform	ned? prid	or to completion of cause of ath?
tal Fen: The tificate tor, pag	ပိ	25. Was case referred to medical				26 Place o	1 ☐ Yes 2		Yes 2□ No
of Vita Physicien: this certific	o B	examiner?	ospital:	ER/Outpatie	nt 3 DOA Oth	or	sing Home 5 Reside	(A)	(Specify)
Of Phys or this oral di	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year		of 28c. Injur	y at		w injury occurred	
lon or nding I th.	atio	1-☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	) Injury	Wor M 1□	Yes 2 □No	0		
Division of Vital Records, at or Attending Physicien: The law requires Is affer death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge, deal	h occurred at the tir	me, date and	place, and due to the ca	ause(s) and manr	ner as stated.
ne Ho n 24 h ne Fui	Medical	(Check only 2 Medical Examinons)	ner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	ppinion, death	occurred at the time, d	ate and place, an	d due to the cause(s)
To the within 2 To the comple	Ž	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (	(Month, Day, Year)
7 map	1	VVINY			1000	605	35 /	pail 11	6,2004
VA	1 8	30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type, HEALT	Print)	DR	BERLIN,	m X	11811
1	ate	31. Date filed (Month, Pay Year)	32. Regigirar's Si		1 dog	1	DUIL-110)	11000	VL U - 1
Regist		APR 2 3 2	UU4 100	/	popul	W			

			1 - For State Registrar	State of Marylan		rtment tificate			and Me		ene 2 (	004	15510
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Las Ruth G      Aa. Fecility Name (If not institution, give D)	Nuertenba	e star	4b. City, T	Town, or I	ocation o		Date of Death Month April	Day 26 4c. County	Year 2004 of Deeth	3. Time of Death 9:04AM
	Funeral Director		5. Social Security Number 6. Se 155-05-6461 Usual Residence of Decedent		last birthday) Yrs.	If Under 1	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min. A	Date of Birth (Month, Day, LIGUST 22,		9. Birthpl Count	ace (State or Foreign try) nsylvania
36	y within 72 hours after deeth with the Maryland liene. r then "natural", or teme 23a or 28a-f show the Markical Examiner rust be notified at	by Funeral Director	10a. State 10b. County  Maryland Wicomic  10e. Street and Number  1112 Middle Neck 1  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Micorced	co Sa		Y 101. Zip ( 21.	804 ent of His fy Cuban	panic Orig , Mexican, Specify:	gin? (Specif , Puerto Ric	fy Yes or No- can, etc.)		What Count e - America ck, White, e	an Indian, etc.
d 21215-0036	Hyg Hyg othe	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	ucation	life. L	lent's Usual kind of work DO NOT use	k done du e retired)	iring most		First, Middle, M	Govern	usiness/Ind	,
, Maryland	d 2 should th and Mer 7 Is marke traumatic	To Be	Solomon  19a. Informant's Name/Relationship (7)  Alan N. Wuertenber					nd Numbe		 Route Number, Salisbu	City or Town,		Code)
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 2005.		20a. Method of Disposition  1 Burial 2 XCremation 3 4 Donation 5 Other (Specify,  21. Signature of Funeral Service Lights	Removal from State Sal	22 H	natory or other Crements of Colors	nator Nator I Address Ay Fi	y Ap unera	il Hom	7, 2004	essiona	sbury al Ass	, Maryland sociation
8760,	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused the death ne cause on each line.  a. Congress  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):  X, W  uence of):	er the mode	of dying,	such as o	cardiac or re		st,	-	Approximate Interval Between Onset and Death  Welker  Perental
P.O. Box 687	death certific e attending p ad for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna. 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 🗌	Ectopic pred				3	23d. Dat Mo	e of deliver	y Day Year
Records, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the un	derlying ca	use giver	in Part I.			2 No	ribute to the	e cause of death?
Vital Rec	The ate h page	Be Completed	25. Was case referred to medical examiner?					26. Place	of Death (C	24a. Was an autopsy perform 1 Yes 2, Check only one	ed?		sy findings available in pletion of cause of
Division of V	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	2	1 Yes 2 No  27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	1   Inpatient 2   1   Inpatient 2   1   28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		c. Injury a Work?	4 Nur	280	5 Resident. Describe how		, ,	
Divis	the Hospitel or Att thin 24 hours atter d the Funeral Direct mpletely filled in by t	sal Certification:	3 Suicide 4 Homicide  29a. Certifier  12 Certifying Phy	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known	v) wledge, death	occurred at	t the time	, date and	i place, and	. Location (Stre City or Town,	State)	nner as sta	ited.
)	To the Ho within 24 I To the Fu	Medical	29b. Signature and title of certifier  30. Name and address of person who certifier	ner: On the basis of examinat and manner stated.									
D	Sta Registr		Inja HW4ng 31. Date filed (Month, Day, Year)  APR 2 8 200	32. Registrar's Signat	Box ture	2018	s, s	SALI	SBY	290 4 8 R.Y., M	0 24	802	

			Fleas	e Type or Print in					
			For State	State of Maryla			na Mentai Hyg		1 1000
			Registrar		Certifica	ate of Death		g. No. 200	4 1551
8 .	Physici		Decedent's Name (First, Middle,	Α			2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic		Alvin L	Anderson			MAY	7 200-	
7	Examin	er	4a. Fecility Name (If not institution,		4 . 1	ity, Town, or Location of		4c. County of Deet	h
			University of	Maryland Medi	cal Center	Baltim		NIA	
6.4	Funeral		5. Social Security Number	S. Sex 7. Age (In y	Monti	der 1 Year If Under 24 hs Days Hours	Min (Month Day	Year) 9. Birt	hplace (State or Foreign ountry)
	Director	c	21354 1470	3 9	Yrs.		160,30	1449 MA	ny/min
	D s		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Location				10d. Inside City Limits
	sho	_		1.					1 √es 2 No
	Ne M	Director	MAKY/son ~/	#	BAHANO	Zip Code	11	og. Citizen of What Co	untar?
	vith t	ä	10e. Street and Number	a us a Ob	77	•	."		
	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show dicel Evantreer must be notified at	Funeral	2401 08.01	12. Was Decedent Ever in		2/3/6	2 (Specify Ves or No.	14. Race - Ame	
	er de Item	nne	11. Marital Status	Armed Forces?	If Yes, s	ecedent of Hispanic Origin specify Cuban, Mexican,	Puerto Rican, etc.)	Black, Whit	e, etc.
36	s aft	by F	1 Never Married Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes _2☐ Ho If Yes, Give Year or Dates:	1 □ Ye	s 2 Specify:		Specify: B	1. 1
5-0036	hour	P	15. Decedent's		16a. Decedent's U	Isual Occupation		16b. Kind of Business	Industry
5	n 72	Completed	(Specify only highest	grade completed)	(Give kind of life. DO NO	work done during most of Tuse retired)	f working		
121	within ene. than	m	Elementary/Secondary (0-12)	College (1-4or 5+)	Ch 1	vkee		Samonii 1	Toint
2	filed Hygid ther ant, I		17. Father's Name (First, Middle, L.	ast)	41687 600	/ -	Name (First, Middle, A	aiden Surname)	
ğ	Mental I	Be	11111 m. P.	1 11 200		A	ce Com		
Maryland	d Men narke	ဥ	19a. Informant's Name/Relationshi	Tuna Print	10h Mailing Addr	ess (Street and Number			Zin Code)
Ma	12 sho h and 7 is m		19a. momants Name/Helationshi	(Type, Film)	3640 B	Jok Osk		2.//	100/
	1 and Health em 27 ther tr	-	In CLUEL DE IND. 20a. Method of Disposition	Ersin Julie	b. Place of Disposition (	Name of	Date /	20c. Location - City or	Town, Stete
altimore	So to to		Burial 2 Cremation	3 □Removal from State	cemetery, crematory	or other place)	5-/13/01	a -	/
Ē	permit. Pag Department Important: I any injury c	١.,	4 □ Donation 5 □ Other (Sp.	7	LBUTUS /MC	merial Park	000	TUBUTUS //	any as
Ball	permit. Departr Importa any inj		21. Signature of Funeral Servic-L	nsee	22. Name	and Address of Facility  O LELT TER	String Lein	Mon is or	WED WHE
	0.0 ≥ a d		France / Vel	Ji.	BAL	not mel	21218		
			23a. Part 1 Enter the disease, or of shock, or heart failure. List of	complications that caused the d nly one cause on each line.	leath. Do not enter the r	node of dying, such as ca	ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician		In late Cause (Final isease or condition	Peritor	ritis				Oliset and Death
	/Medical		resulting in death)	Due to (or as a con-					1 1
-	Examiner	Н	0 1 1 5 5 5 5 5 5	Ishemi	a Bowel				1 day
	DIE CO	Je.	if any, leading to immediate	Due to (or as a con-	sequence of):				
	d d ansii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 Sepsis					
á	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a con-	sequence of):				
760	sicia Psicia e bur	cal	1	d					
.89	certificate Iding phys Ise as the	Physician/Medi				<del> </del>			
Box	ndin use	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre				23d. Date of de	livery
m	death e atter	cia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 F 4 Pregnant at time		ic pregnancy (specify)		Month	Day Year
P.O.	the cy the	ysi	9 Unknown	9□ Unknown					
	requires that the de been signed by the s should be detached	y P	Part II. Other significant condition	s contributing to death but not	resulting in the underlying	ng cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
sp	requires een sign tould be	d by					1 □ Y€	es 2□No 3□P	robably 4 Unknown
Division of Vital Records,	v req beer shou	Completed					24a. Was a	n 24b. Were a	utopsy findings available
žě	e lav has je 2	mp					autops perform	y prior to ned? death?	completion of cause of
=	pa age						1 ☐ Yes 2	No 1 □ Yes	2 □ No
=======================================	Physician: this certific al director.	Be	25. Was case referred to medical examiner?	Hospital:			of Death (Check only on		
of	this al di	မ	1 ☐ Yes 2 No	28a, Date of Injury	2 ER/Outpatient 3	28c. Injury at	ing Home 5 Reside	ence 6 Other (Spe	cify)
ď	E E	o o	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Yee		Work? 1 ☐ Yes 2 ☐ N		w injury occurred	
sic	uttendii death. ctor: A y the fu	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be				reet end Number or R	usal Dauta Numbas
≅	fter of free o	E	4 Homicide determin		At home, farm, street, fac necify)	стогу, оптсе	City or Town		urar noute Number, sp
	real C	ပိ				V V V V V V V V			
N	Hosp 4 hou Fune ely fi	edicai	(Check only 2 Medical E	Physician: To the best of my examiner: On the basis of exam	knowledge, death occur nination and/or investiga	red at the time, date and tion, in my opinion, death	place, and due to the ca occurred at the time, d	ause(s) and manner a: ate and place, and du	s stated. e to the cause(s)
/	the lin 2, the I the I	led	one)	and manner stated.		an Liveren symbol		Od Data singed (Man	th Day Your
	To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	1112		PI6492		9d. Date signed (Moni	
			1 4 hr 2	roun MD		110712	- /	MAY 7,	2004
P	7		30. Name and address of person v	who completed cause of death	(Item 23a) (Type, Print)	T DATE	MADDE MA	N 2120	
_	$U_{\perp}$		JORGE LOZAN	0 272	KEENE >	1. BITU	ANCOICE ! A.C.	0 2120	·
		ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature 💪	T. BALTI			
		rar	MAY 14	THIS PARTY	- 10 04	UULKU			

		1 - For State Registrar	State of Mary		artment ertificate			and M	lental Hy	giene	201	N.L. 1	551/
Physic	ion	Decedent's Name (First, Middle, Last)							2. Date of De		Yea	3. Time	or Death
Physic /Medi		Melvin Dillon Al							May	10	200	7:10	P M
Exami	ner	4a. Facility Name (If not institution, give stre 1306 Midvale Avenu					Location o	of Death			County of De		
Funeral		5. Social Security Number 6. Sex		yrs. last birthday	) If Under	1 Year	If Under		8. Date of Bi		altimo	irtholace (State	or Foreign
Director		234-22-3546	1 2□F	89 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Da March	23,1	915 We	country) st Virg	inia
and		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or I	ocation							10d. Inside	City Limits
Mary 9-f sh	tor	Maryland Baltimore	e	Cato	nsvill	e						1 ☐ Ye	s 2 No
th the or 28¢	Oirec	10e. Street and Number			10f. Zip	Code				10g. Citi	zen of What	Country?	
ath wi	la	1306 Midvale Avenu				212				U.S			
ter de	Funeral Directo	11. Marital Status 12.  1 □ Never Married 2 ▼ Married	Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	in U.S. 13	. Was Deced If Yes, spec	ent of His fy Cubar	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ar Black, Wi	nencan Indian, hite, etc.	
036 ours af	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2	K) No	Specify:				Specify: Wh	ite	
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28e-f show event, the Medical Exer a set must be rediffed at	Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	(Giv	edent's Usua e kind of wor	k done d	urina mos	t of worki	ing	16b. Ki	nd of Busines	ss/Industry	
within within than than	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us 1 Work	,					Steel		
d 2 filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)		bcee.	I WOIK		18. Mothe	er's Name	First, Middle				
aryland should be and Mental I s marked o	To B	George Edward Alt					Emma	a Shi	reve				
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours af if Health and Mental Hygiene. item 27 is marked other than "natural", or other treumatic event, the Medical Exert	ľ	19a. Informant's Name/Relationship (Type,	Print)	19b. Mai	ling Address	(Street a	nd Numbe	er or Rura	al Route Numb	er, City o	r Town, State	, Zip Code)	
e, N l and lealth om 27 ther tr		Imogene Kimble Alt	(Wife)						atonsvi			and 212 or Town, State	28
altimore, mit. Pages 1 ar partment of Hea portent: If item 3 y injury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem		Ob. Place of Disposemetery, cr				May	14.		-510		
Baltimol permit. Pages Department of Importent: If it any injury or once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Ligensee</li> </ul>	. 1	Wilson (	22. Name and	Addres	s of Facilit	tv			r Trac		
Dep Per Substitution		Beman	Talpera	Cer Y	itzke 530 Ed:	Fune nond	ral H son A	iome Iveni	of Cat ie Cato	onsv nsvi	ille, <sub>M</sub>	Inc. aryland	21228
		23a. Part1. Enter the disease, or somplical shock, or heart failure. List only one	tions that caused the cause on each line.									Approxim Interval B	ate etween
Physician		Immediate Cause (Final disease or condition	END STA	GE MUI	LTINE	RIT	DE	MEN	ITIA			2 WZ	Death
/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):									
	ē.	Sequentially list conditions, if any, leading to immediate	PARKIN Due to (or as a co										
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										:	
8760, rate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):	-								
Hecords, P.O. Box 68760,  The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	<b>d</b>											
Box 68 leath certifica attending ph	Physician/Med	IF FEMALE: 23c	If yes, outcome of pr	regnancy							23d. Date of o	daliman	
Box death cert attendin	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at time	Fetal death 3	☐Ectopic pre						Month	Day	Year
P.O.	hysi	9 Unknown	9□ Unknown										
IS, P.O.	ру Р	Part II. Other significant conditions contril	outing to death but no	t resulting in the	underlying ca	use give	n in Part I					to the cause o	
cords w require been signature	ted	1 12Hambrs							1 🗆	Yes 2	□ No 3 □	Probably 4 [	<b>⊒</b> Unknown
Hec e law has b	Completed								24a. Was		24b. Were prior to death	autopsy finding to completion of	s available cause of
	e Co	25. Was case referred to medical						17	1 Yes	2 No	1 🗆 Y		
ysicia ysicia s cert	0 0	evaminer?	pital:	2 ER/Outpatio	ent 3 DO	A Othe	F		n (Check only me 5 € Res		6 ∏Other (Si	pecify)	
ng Phy ter thi	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea			Bc. Injury Work			28d. Describe				
SIOI tendir eath. or: Af	catlo	2 Accident investigation		,	М		′es 2 □						
DIVISION Of  I or Attending Physicater death.  Director: After this  in by the funeral di	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, s pecify)	treet, factory	office				(Street an wn, State		Rural Route No	ımber,
Spitel		29a. Certifier 1 Certifying Physic	an: To the best of my	/ knowledge, dea	ath occurred a	it the tim	e. date an	nd place.	and due to the	cause(s)	and manner	as stated.	
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, is	edical	(Check only 2 Medical Examiner one)	On the basis of exa and manner stated.	mination and/or i	nvestigation,	in <i>m</i> y op	inion, dea	th occurr	ed at the time	date and	place, and d	lue to the cause	(s)
To the To the Comp	Ž	29b. Signature and title of certifier			İ		number					onth, Day, Year,	
1		what of few				145	931			MA	( 1)	,2004	
5		30. Name and address of person who comp	leted cause of death	(Item 23a) (Type	Print)	n	712	08					
Sta	ate	31. DMAY (Nont'4 P2004)	AVE /	Signature	and I	/	616						
Regist		WIA1 1 ± 2004	<b>)</b> /	14									

		1 - For State Registrar	State of Maryland /	Depa		lealth and N	/lental Hyg	iene 19. No. <i>(</i>	2004	1551
Physici /Medi	cal	1. Decedent's Name (First, Middle, Las Diane Ahlm	an		4b City Tourn	r Location of Death	2. Date of Deat May 5,	2004		3. Time of Death 1:30PM M
Examir	ner	4a. Facility Name (If not institution, give 8393 Fordham Co			Union	Bridge		Fr	ounty of Deeth edericl	
Funeral Director		5. Social Security Number 6. S 54-74-4916  Usual Residence of Decedent	The office	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 4,	<b>Year)</b> 1946	9. Birth	place (State or Foreign ntry) Ohio
h the Maryland or 28a-f show	irector	10a. State 10b. County  Maryland Freder:  10e. Street and Number	i.ck Uni		cation Bridge 10f. Zip Code		11	0g. Citize	n of What Cou	10d. Inside City Limits 1 ∰Yes 2 ☐ No intry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If them 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Maryloal Examinar must be notified at 2008.	by Funeral Directo	3393 Fordham Court  11. Marital Status  1□ Never Married 2\mathbb{M} Married  3□ Widowed 4□ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		21791 Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		U.S.A. Race - Ameri Black, White,	
in 72 hou n "nature	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		a. Deced (Give life. L	dent's Usual Occup kind of work done OO NOT use retired	ation during most of work d)	king	16b. Kind	of Business/Ir	ndustry
d 2 should be filed with th and Mental Hygiene 7 Is marked other tha traumatic event, the	Be Com	17. Father's Name (First, Middle, Last)	5+	Nur	se	18. Mother's Nam	ne (First, Middle, M	Maiden Su	Health mame)	n Care
nould be d Menta marked matic ev	ToB	James Frederick A		h Mailin	on Address (Street	Ann and Number or Rus		elsen Civer I		n Code)
1 and 2 st Health and om 27 is r ither traur		John L. Ballantyr	ne/Husband 8	3393 of Dispo	Fordham	Court, Un	nion Brid	dge,		nd 21791
L. Pages trnent of I tant: If Its ijury or o		1 🔀 Burial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Specification 1)	Removal from State cemet Resthav	ren Me	natory or other plac emorial Gar	dens May				Maryland
Departiment of the policy of t		21. Signature of Funeral Service Licer	Mª Millian	Į Ž	Leeney ar 106 East	ss of Facility nd. Basford Church S	d PA Fund t., Fred	eral erick	Home MD 2	1701
Physician /Medical Examiner	her	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	one cause on each line.  a.   Due to (or as a consequence)  Due to (or as a consequence)	e of):	Cana					Approximate Interval Between Onset and Death
ficate be executed physician and is the burial-transit	edical Examiner	cause. Enter Undertying Cause (Oisease or injury that initiated events resulting in death) Last	c	e of):						
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quires that n signed b uld be deta	ρ	Part II. Other significent conditions (	contributing to death but not resulting	j in the u	nderlying cause giv	ven in Part I.	23e. Did tot		/	the cause of death? bably 4 DUnknown
The ate h	Completed						24a. Was a autops perform	У		opsy findings available ompletion of cause of 2 No
ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatien	nt 3 DOA Oth	ar:	ome 5 Heside		Other (Speci	(fv)
ling Ph I. After th funeral	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b (Month, Day Year)	. Time of	28c. Injui	ry at rk? Yes 2 □ No	28d. Describe ho	ow injury o	occurred	,
ital or Attending rs after death. rate Director: Afte led in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		farm, str	reet, factory, office		28f. Location (St City or Town	reet and I n, State)	Number or Rur	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai		nysician: To the best of my knowled miner: On the basis of examination a and manner stated.							
To th To th Compl	Me	29b. Signature and title of certifier	(lym)		29c. Licens	48184		May	6, 200	04
\		30. Name and address of person who Einamy Eskand		a) (Type,	Print) the street	et Frede	ericky N	1D	2170	
St Regis	tate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	9 ,	Sparke					

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 11, 2004 **Physician** F. Allard Helen 6:10 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Millenium South River Edgewater
If Under 1 Year If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year) 11/22/1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🖾 F 88 578-28-3765 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State a 23a or 28a-f show Anne Arundel Shady Side Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20764 USA 1308 Holly Street r than "naturel", or Itema 23a of the Medical Examiner must b 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 21 No Il Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 Yes 20 No Specify: Specify: White Completed by x8√3Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tube Cutter Paper Tube Co. 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F Pages 1 and 2 should be Alexander Wilson Sally Chambers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other tra P.O. Box 346 Shady Side, Maryland Joan D. McPhillips / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State NZ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. \* 4 ☐ Donation \_5 ☐ Other (Specify) Md. Veterans Cem. 05/14/2004 Cheltenham, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending pl 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Compieted by EREDROVASCULAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 ☐ Yes 2√√No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 Yes 2€XNo Certification: To 4√Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1XXNatural 5 🗋 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 🗌 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce D57028 05/11/2004 30. Name and address of person who completed cause ol death (Item 23a) (Type, Print) 600 Ridgley Avenue #231 Annapolis, Maryland Aditya Chopra 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 4 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	/larylan		artmen rtificate			and Me		giene Reg. No.	/ 11 1	14	15516
	DI		1. Decedent's Name (First, Middle, La.								2. Date of De Month	ath Day	Y	ear	3. Time of Death
	Physici: /Medic			<u> </u>	BRY	ANT		_			MAY	6	200		2:06PM
	Examin	er	4a. Fecility Name (If not institution, give			ard.	, ,		Location o				County of		
			9109-B Town & 0	Country Bo		IECI last birthday)	If Under		If Under		8. Date of Bir				ace (State or Foreign
b	Funeral Director			MM 2□F		51 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da AUG 12	$2, \stackrel{\text{Year}}{1}9$	42 <u>1</u>	Mass	achusetts_
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside City Limits
	Ba-f el	cto	Maryland Howard		E11	icott									1 ☐ Yes 2 і No
	ith th	Funeral Director	10e. Street and Number				10f. Zip					7	zen ol Wh	at Coun	try?
	s 23e	Frai	9109-B Town & Co	ountry Bot 12. Was Deceder				1043	snanic Orig	ain? (Spec	rify Yes or No	USA -	14. Race -	Americ	an Indian.
	ther de	Fun	11. Marital Status 1 ☑Never Married 2 ☐ Married	Armed Force 1 Yes 2 If Yes, Give	s?	71				Puerto F	cify Yes or No Rican, etc.)			White, 6	etc.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Madical Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date:	s: 198	32	1 🗌 Yes	2 X No	Specify:				Specify:		White
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest gra	lucation de completed)		16a. Dece	kind of wo	rk done d	turing most	t of workin	g	16b. Ki	nd of Busi	ness/ind	lustry
121	within sne.	mpi	Elementary/Secondary (0-12)	College (1-4c	or 5+)	Nurse	DO NOT u: S	se retirea	)			Hea	lthca	are	
9	filed Hygie other		17. Father's Name (First, Middle, Last,	. 4		110201			18. Mothe	r's Name	(First, Middle	1			
lan	fental fental rked c	To Be	Edward M. Bryant						Dor	othy	W. Wya	att			
ary	2 shot and N is ma		19a. Informant's Name/Relationship (				0.0				Route Numb			ate, Zip	Code)
≥,	and lealth m 27		Rev. Susan LaMar	Clergy	20h E		Betha				Licott		cation - Ci		.042
jore	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from Sta	le i	Place of Disponentery, crea			_ '					-	
Baltimore,	그 든 문 중 .		*4 □Donation 5 □Other (Specification 21. Signature of Funeral Service Licer	(200	τ.	etro Ci				5 <b>-1</b> 3			ltimo	ore,	רוט
Ba	permi Depa Impo any is		Edward A.	perorchi	k		orema 299 Fi	rede:	Soci rick	ety o Road	of MD, Bal	inc. Ltimo	re, l	MD	21228
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	/Medical Examiner		resulting in death)		as a conseq			,							
Ь	Examine:	٦.	Sequentially list conditions,	b. Due to (or	as a conseq	uence of):									
	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
ć	te be executed ysician and e burial-transit		thet initiated events resulting in death) Last	Due to (or	as a conseq	uence oi):									
3760,	eath certificate be executed attending physician and for use as the burial-transit	Ical		d											
89 x	death certifical e attending phi d for use as th	Physician/Med	IF FEMALE:	00- 16									II. 1975	1	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 Live birth 4 Pregnant	2 Feta	Ideath 3	∃Ectopic pr ∃ Other (sp					1	23d. Date of Month		ry Day Year
o.	0 0	ysic	1 Yes 2 No 9 Unknown	9□ Unknowr											
Q.	es that the igned by th be detache	by Pi	Part II. Other significant conditions								23e. Did 1	tobacco u	se contrib	ute to th	e cause of death?
Records,	The law requires ite has been sign bage 2 should be	led t	pacemaker, ch	induic ob	struc	hive p	ulma	nary	1 disc	case	1 🗆	Yes 2	□No 3	rob	ably 4 □Unknown
ecc	has be	Completed	obesity								24a. Was	psy	pric	or to cor	psy findings available inpletion of cause of
<u>=</u>		Con	•								1 ☐ Yes	omed?		ath? ] Yes	2 D No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		500		Oth	00		(Check only	,	C 🗆 🗆	10	
of		. To	1 No 27. Manner of Death	1 ☐ Inpa	njury	28b. Time of		8c. Injun	/ at		ne 5 Resi 8d. Describe		6 □Other y occurred		//
ion	Attending Phir death.  ector: After thiby the funeral	ation	1 Accident 5 Pending investigation		Day Year)	Injury	М	Worl	Yes 2	No					
Division	r Atte	Certification;	3 Suicide 6 Could not be determined	289. Place of	Injury - At h		reet, factor	y, office		2	8f. Location ( City or To			or Rura	l Route Number, .
	urs aft real Di														
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Medical		nysician: To the be miner: On the basis and manner	s of examina										
	To th within To th comp	Me	29b. Signature and title of certifier		De	بتكنيه			e number	_		29d. Dat	e signed (	Month, I	Day, Year)
	11/1		Matmu S-	Magn	M	ME			147			MAC	191	200	4
	1X		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type,	Print)	A Tar	V 600	1 -	મોવ્સ (	· . —			21/2
	J		31. Date liled (Month, Day, Year)	32. Regi	istrar's Signa	amre "	ck le	300	WK	۲, ال	यक्ता ८	279	NLY	121	042
	Sta Regist		marin A 300A	Sance		9 1	soul	1							

		1	For State Registrar	State of Maryland	-	rtment of Health tificate of Deat			ne 200L	15517
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Mary	Byrd				2. Date of Death Month	Day Seer	3. Time of Death 4 15:20 M
	/Medic Examin		4a. Fecility Name (If not institution give s Howwood Con	treet and number)	Hosp	4b. City, Town, or Location	unit	ria	4c. County of Deat	
	Funeral Director		219-22-0311	M PD F 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year If Under 1 Months Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day, Y	9. Birt Co	hplace (State or Foreign untry)
	Aaryland I show		Usuel Residence of Decedent  10a. State  10b. County  Many Ann  Librar Man	10c. City, T	1 1	eation SIA	_			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the h s or 28s-	Direct	10e. Street and Number	Fr. 7	e MO	10f. Zip Code	14	10g	Citizen of What Co	
	within 72 hours after death with the Maryland ene. than "natural", or tiems 23a or 28a-f show than Medical Exacilinat must be notified at	by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. V	Vas Decedent of Hispanic ( Yes, specify Cuban, Mexic	Origin? (Spe can, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	ncan Indian, e, etc.
21215-0036	2 hours at	ted by	15. Decedent's Educ (Specify only highest grade		16a, Deced	ent's Usual Occupation kind of work done during m		16	b. Kind of Business	
2121	ed within 7 glene. er than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. L	OO NOT use retired)		0	was Kon	<i>c</i> -
Maryland	should be filed nd Mental Hygi marked other umatic event, I	To Be	17. Father's Name (First, Middle, Last)			n.	mal			
_	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (Ty)	son lowight	166		Way	Balt	MAR, Ru	1334
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exacility of must be notified at ORGS.		20a. Method of Disposition  Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from state	Inin	sition (Name of natory or other place)	5/1	3/04 /2	c. Location - City or	w, Mury 1.ms
Ball	permit. Pag Department Importent; eny injury c	y V	21. Signature of Funeral Service Liones	٠	B	Name and Address Face  YO KEISTEN  HARRINGE	21311			
**	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.		er the mode of dying, such	, ,,	n -		Approximate Interval Between Onset and Death
	/Medical Examiner	<i>(</i>		Due to (or as a consequer	die	lous				
	te be executed ysician and le burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer  Due to (or as a consequer	loc	egulopa	thy			
8760,		icai		Rh.		longelise				
P.O. Box 6	death certif e attending ed for use a	Physician/Med	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
	uires that the de n signed by the a ld be detached f	Ď	Part II. Other significant conditions con	stributing to death but not resulting the surface of the surface o	ng in the ur	nderlying cause given in Pa	rt I.		cco use contribute to	the cause of death?
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	prior to	itopsy findings available completion of cause of
Division of Vital		To Be C	25. Was case referred to medical examiner?  1 □ Yes 2 No	lospital: 1 XInpatient 2 □ EF	VOutpatien	Other		(Check only one)	ce 6 □Other (Spe	cify)
sion o	fter fter	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury at Work? M 1 □ Yes 2	□No	28d. Describe how		
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				City or Town,		
<u></u>	the Hosp in 24 hou the Fune upletely fil	ledical	(Check only 2 Medical Exeminate)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	n and/or inv	estigation, in my opinion, d	leath occurre	ed at the time, date	and place, and due	to the cause(s)
)	5 Wild	Σ	29b. Signature and title of certified	- M		D50 8	370	7)	Date signed (Mont	n, Day, Year) Th 2004 MJ 21029
	2		30. Name and address of person who co			Print) Bell	Ln.	Clark	isull!	MD 21029
ŕ	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 4 2004	Server Signatur	9	Sports				

ORIGINAL

			For State Registrar	State of Ma	ryland / [	Departr <i>Certifi</i>	ment of H <i>icate of L</i>	eaith and M D <i>eath</i>		ene 20	04 15518
	Obveisi		1. Decedent's Name (First, Middle, La	ast)					2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		William Josep	oh Brobst					May	10 2a	14 2024 M
	Examin	er	4a. Facility Name (If not institution, gi					Location of Death		4c. County of E	Death
		Š.,	Union Memorial I  5. Social Security Number 6.	-	(In yrs. last bin		Baltimo Under 1 Year	re If Under 24 Hrs.	8. Date of Birth	9	Birtholago /State or Foreign
	Funeral Director			1⊠M 2□F			onths Days	Hours Min.	Month, Day, March 18	,1926 Pe	Birthplace (State or Foreign Country) ennsylvania
	D v		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Locatio	20				10d, Inside City Limits
	shor	5									1 ☐ Yes 2 ☑ No
	the A	Director	Maryland Baltin	lore	West		Of, Zip Code		100	g. Citizen of Wha	t Country?
	with Ba or		5436 Channing	Road			212	20			,
	death ms 2:	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was		spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No-		American Indian,
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23s or 28s-f show the Musical Esticilies inval be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces?  1 ☑Yes 2 ☐ No	。 WW II		s, specity Cubai Yes 2⊠ No	n, mexican, Puerto  Specify:	Hican, etc.)	Specify:	Vhite, etc.
3	hour tural	ed b	15. Decedent's E			Decedent'	's Usual Occupa	ition	16	Sb. Kind of Busine	White
21215-0036	in 72 n na	Completed	(Specify only highest gi	ade completed)		(Give kind life. DO f	d of work done d NOT use retired,	ition luring most of work )	ing	., ,	,
212		Ho	Elementary/Secondary (0-12)	College (1-4or 5-	-)	Secu	rity Of	ficer		Postal (	Office
	it it it	Be C	17. Father's Name (First, Middle, Las	t)				18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
<u>a</u>	O ≒ D ●	To	Paul Brobst					Sarah Ed	lwards		
Maryland		·	19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing A	ddress (Street a	and Number or Rur	al Route Number,	City or Town, Sta	te, Zip Code)
	of Health item 27 other tra		Barbara Stricker	(Daughter					Catonsv		
9	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of cemeter	y, cremato	n (Name of ary or other place	9)		Oc. Location - City	
altimore,	tant:		*4 □ Donation 5 □ Other (Spec		Crest1	1			4-2004 M	arriotts	ville, Maryla
Ba	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Lie	Dalmer	the	W163	ke Fune C Edmon	ral Home dson Ave	of Caton Catonsvi	syille, lle, Már	Inc. yland 21228
*			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that caused	the death. Do						Approximate Interval Between
3.	Physician		Immediate Cause (Final disease or condition		ive He						Onset and Death
	/Medical		resulting in death)	Due to or as a	consequence	of):	anole				710012
300	Examiner		Sequentially list conditions,	6 Cosolary			isease				10 Years
47	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	of):					
	and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	ot).					
8760,	cate be executed physician and the burial-transit	aiE				5.7.					
287	ficate phys s the	edicai		d			· · · · · · ·				
Box	eath certifi attending I for use as	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of	delivery
ň	death certiff e attending id for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t			opic pregnancy her (s <i>pecify)</i>			Month	Day Year
J.		hys	9 Unknown	9□ Unknown							
	as the gned	by P	Part II. Other significant conditions	contributing to death bu	t not resulting in	the under	lying cause give	n in Part I.	23e. Did toba		e to the cause of death?
ğ	w require been signature								1 🗆 Yes	2 □ No 3 €	Probably 4 Dunknown
Records,	law n as be	Completed		· · · · · · · · · · · · · · · · · · ·					24a. Was an autopsy	24b. Were	a autopsy findings available to completion of cause of
	sician: The law certificate has l irector, page 2 s	Con							performe 1 ☐ Yes 2	eg/? deat	h? Yes 2☑No
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	IIiI-l					n (Check only one)		
ot	Phy this ald	To	1 Yes 2 No		nt 2 ER/Ou				me 5 Residen		Specify)
2	ing After une	ion	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of njury	28c. Injury Work		28d. Describe how	injury occurred	
S	Attending or death.	icat	2 Accident investigation 3 Suicide 6 Could not	be on Blace of Injur	rv - At home fa			-	28f Location (Stre	et and Number o	r Rural Route Number,
Division	ital or Attend irs after death ral Director: , lled in by the f	Certification:	4 Homicide determine	building, etc.	(Specify)	, street,	raciory, office		City or Town,		isla . isla
_	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in I		29a. Certifier 1 Certifying F	hysician: To the best o	f my knowledge	, death occ	curred at the tim	e, date and place,	and due to the cau	ise(s) and manne	r as stated.
1/	To the Hospi within 24 hou To the Funer completely fill	edical	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination an led.	d/or investi	igation, in my op	inion, death occur	red at the time, dat	e and place, and	due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	7			29c. License	number	290	d. Date signed (M	lonth, Day, Year)
•	Į.		175	mp			At2439	9446	m	a4 10	2.004
	0		30. Name and address of person who				t)				2
	V			mp 2011 32. Registra	E. Unive	SITY	Parkw.	er Balt	imere My	212	.18
	Sta Registr		MAY 1 4 2004	DEPARTSITA	3 Signatus	do	acted	Ball			
100				/		. /					

/Medi	an cal	ANN MARIE	BELLANCANNE MARTE	BELINIC	2. Date of Death Month	Day Year 3. Time of De
Exami		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Death		4c. County of Death
		HARBOR HOS  5. Social Security Number 6. S	PITAL CENTER  Sex 7. Age (In yrs. last birthday	BALTIMORE  (i) If Under 1 Year   If Under 24 Hrs.	O Data of Birth	BALTIMORE CI
Funeral Director			1 □ M 2 🕦 F 92 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 06/17/191	
how	_	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City L
r 28e-f show	Funeral Director	MD Baltimo	ore Cato	nșville		1 🗆 Yes 2
23e or 2 ust ban	Dir	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
ms 2	nera	425 S. Rolling RI		21228  . Was Decedent of Hispanic Origin? (Spull Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
ital Hygiene. Id other than "natural", or Items event, the Medical Examinar in	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, etc.  Specify:
"natural", idical Ex	ed b	15. Decedent's E	Year or Dates: ducation 16a, Dec	edent's Usual Occupation	161	White  D. Kind of Business/Industry
Media.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)  (Giv	e kind of work done during most of works DO NOT use retired)	ing	s. raid of basinosa industry
other than oent, the M	Con	8	Но	memaker		Own Home
Mental H arked ott atic even	Be	17. Father's Name (First, Middle, Last,	)		e (First, Middle, Mai	den Sumame)
of Nealth and Menta	70	Michael Pavlo  19a. Informant's Name/Relationship (	Type, Print) 19b Mail	Helen Vi		ity or Town State Zin Code)
27 is 17 is 17 treu		David Belinic/Sor			timore, M	
of Health fitem 27 i r other tre		20a. Method of Disposition	20b. Place of Disp	the same of the sa		c. Location - City or Town, State
ent: If		1 2 Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif	Juentoval Holli State	Cemetery 05/18	/2004 Fe	rrell, PA
Uepartment of Importent: If any injury or once.		21. Signature of Funeral Service Licer	S S	22. Name and Address of Facility Sterling Ashton Sch 36 Edmondson Ave.	wab Funer Baltimor	al Home, Inc.
		23a. Pa 11. Enter the disease, or com mock, or heart failure. List only	plications that caused the death. Do not er one cause on each line.			Approximate Interval Betwee
ysician		Immediate Cause (Final disease or condition resulting in death)	a. CEREBRO VA.	SCHILL AR ACCUS	C 4 17	Onset and Dea
<i>l</i> ledical	11 1			JUDIENE NICELL	ENI	1 days
aminer		Tooling in asan,	Due to (or as a consequence of):			
	Je.		Due to (or as a consequence of):	HEART FAILURE		MANY YE
aminer	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of): b. CONGESTIVE			MANY YE
aminer -transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Condest Consequence of):  b. Due to (or as a consequence of).	HEART FAILURE		MANY YE
aminer -transit	ical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Condition of the con	HEART FAILURE		MANY YE
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w the attending physician and ached for use as the burial-transit	ical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. A Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1	HEART FAILURE WITH PLEURAL  DEctopic pregnancy Other (specify)	EFFUS	MANY YE  7 days  23d. Date of delivery  Month Day Year
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has been signed by the attending physician and in 2 should be detached for use as the burial-transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of SEPSIS	Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. A Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1	HEART FAILURE WITH PLEURAL  DEctopic pregnancy Other (specify)	EFFUS	MANY YE  23d. Date of delivery  Month Day Year  2 No 3 Probably 4 Unkr  24b. Were autopsy findings avaing prior to completion of cause
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certificate has been signed by the attending physician and intector, page 2 should be detached for use as the burial-transit in	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of SEPSIS	Due to (or as a consequence of):  b.	HEART FAILURE  WITH PLEURAL  Control  C	23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2	23d. Date of delivery Month Day Year  2 No 3 Probably 4 Unkr  24b. Were autopsy findings avar prior to completion of cause death? No 1 Yes 2 No
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Inter this certificate has been signed by the attending physician and Interest director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  b.	□Ectopic pregnancy □ Other (specify)  underlying cause given in Part 1.  26. Place of Death ant 3□DOA Other: 4□ Nursing Hor of 28c. Injury at Work? M 1□Yes 2□No	23e. Did tobacc 1  Yes  24a. Was an autopsy performed 1  Yes 2   n (Check only one) me 5  Residence 28d. Describe how in	23d. Date of delivery Month Day Year  2 No 3 Probably 4 Unkn  24b. Were autopsy findings avar prior to completion of cause death? No 1 Yes 2 No  6 Other (Specify) njury occurred
Inter this certificate has been signed by the attending physician and Interest director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  b.	□Ectopic pregnancy □ Other (specify)  underlying cause given in Part 1.  26. Place of Death ant 3□DOA Other: 4□ Nursing Hor of 28c. Injury at Work? M 1□Yes 2□No	23e. Did tobacc 1  Yes  24a. Was an autopsy performed 1  Yes 2   n (Check only one) me 5  Residence 28d. Describe how in	23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  24b. Were autopsy findings available prior to completion of cause death? 1   Yes 2   No  6   Other (Specify)  njury occurred
Inter this certificate has been signed by the attending physician and Interest director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  b. Congress Due to (or as a consequence of):  c. A Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1	□Ectopic pregnancy □ Other (specify)  underlying cause given in Part I.  26. Place of Death ant 3□DOA  Other: 4□ Nursing Hor of 28c. Injury at Work? M 1□Yes 2□No  treet, factory, office	23e. Did tobacc  1 Yes  24a. Was an autopsy performed 1 Yes 2 An (Check only one)  me 5 Residence 28d. Describe how in City or Town, Stand due to the cause	23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  2 No 3 Probably 4 Unkn  24b. Were autopsy findings avar prior to completion of cause death? No 1 Yes 2 No  6 Other (Specify) Injury occurred
Inter this certificate has been signed by the attending physician and Interest director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  b.	□Ectopic pregnancy □ Other (specify)  underlying cause given in Part I.  26. Place of Death ant 3□DOA  Other: 4□ Nursing Hor of 28c. Injury at Work? M 1□Yes 2□No  treet, factory, office	23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2 An (Check only one)  me 5  Residence 28d. Describe how in 28f. Location (Street City or Town, Stand due to the cause and at the time, date and the street city or the cause and at the time, date and the street city or the cause and the city or the ci	23d. Date of delivery Month Day Year  2 No 3 Probably 4 Unkr  24b. Were autopsy findings avar prior to completion of cause death? No 1 Yes 2 No  3 6 Other (Specify) njury occurred  and Number or Rural Route Number, are)  a(s) and manner as stated. and place, and due to the cause(s)
Iter this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  b. Congress Due to (or as a consequence of):  c. A Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1	LEART FAILURE   WITH PLEURAL   DEURAL   Other (specify)	23e. Did tobacc  1 Yes  24a. Was an autopsy performed 1 Yes 2 An (Check only one)  me 5 Residence 28d. Describe how in City or Town, Stand due to the cause and at the time, date 29d.	23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  2 No 3 Probably 4 Unkn  24b. Were autopsy findings avar prior to completion of cause death? No 1 Yes 2 No  6 Other (Specify) Injury occurred

Medical Examiner   Sume   Marie   Biller   May   11, 2004   4:30	Physic	ian	1. Decedent's Name (First, Middle, L	·						2. Date of De Month	Day	10/20	04	3. Time of Deat
1903 Annawon Court    See Search Vision Services					Biller						$\frac{1}{2}$	004		4:30 p
South Security Number   Sout	Exami	ner		The state of the s				Location of	Death					_
S26—40—6633   I.O. 2018   See   No. 2018   See					last hirthday			If Under 2	4 Hrs	9 Date of Bird				
Joseph B. Smothers  Joseph B. Smothers  Jessie Burlesson  Jessie Rurlesson  Joseph B. Smothers  Jessie Mailing Address (Sreet and Number or Rural Route Number, City or Town, State, Zip Code)  Diane E. Armstrong / daughter  1903 Annawon Court, Hanover, Maryland 21076  20a. Method of Disposition  1,8 fluid 2   Cremation 3   Removal from State    1,9 fluid 2   Cremation 3   Removal from State    1,0 fluid 3   Cremation 4   Removal from State    1,0 fluid 3   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 5   Removal from State    1,0 fluid 6   Removal from State    1,0 fluid 7   Removal from	Director		526-40-6633	1 M 2 ME						(Month, Da	v. Year)	35	Country Cexa	ce (State or For y) S
Joseph B. Smothers  Joseph B. Smothers  Jessie Burlesson  Jessie Rurlesson  Joseph B. Smothers  Jessie Mailing Address (Sreet and Number or Rural Route Number, City or Town, State, Zip Code)  Diane E. Armstrong / daughter  1903 Annawon Court, Hanover, Maryland 21076  20a. Method of Disposition  1,8 fluid 2   Cremation 3   Removal from State    1,9 fluid 2   Cremation 3   Removal from State    1,0 fluid 3   Cremation 4   Removal from State    1,0 fluid 3   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 5   Removal from State    1,0 fluid 6   Removal from State    1,0 fluid 7   Removal from	Now #		10a. State 10b. County	10c. C	ity, Town or Lo	ocation							100	t. Inside City Lin
Joseph B. Smothers  Joseph B. Smothers  Jessie Burlesson  Jessie Rurlesson  Joseph B. Smothers  Jessie Mailing Address (Sreet and Number or Rural Route Number, City or Town, State, Zip Code)  Diane E. Armstrong / daughter  1903 Annawon Court, Hanover, Maryland 21076  20a. Method of Disposition  1,8 fluid 2   Cremation 3   Removal from State    1,9 fluid 2   Cremation 3   Removal from State    1,0 fluid 3   Cremation 4   Removal from State    1,0 fluid 3   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 4   Removal from State    1,0 fluid 5   Removal from State    1,0 fluid 6   Removal from State    1,0 fluid 7   Removal from	e-is	ctor	MD Anne Ar	undel Ha	nover									1 🕅 Yes 2 🗆
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Joseph B. Smothers   Jessie Burlesson   Jessie Bu	8 238	rai		· · · · · · · · · · · · · · · · · · ·								.A.		
Joseph B. Smothers   Jessie Burlesson   Jessie Bu	He m	nue		Armed Forces?	U.S. 13.	Was Deced If Yes, spec	ent of Hi rfy Cubar	spanic Origi n, Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)	. 1			
Joseph B. Smothers   Jessie Burlesson   Jessie Bu	0 1	by F		If Yes, Give		1 ☐ Yes 2	M K	Specify:				Specify: 1.1	hita	
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Joseph B. Smothers   Jessie Burlesson   Jessie Bu	giene	E O		College (19401 34)	Manag	ger					Res	taura	nt	
Comment   Comm	al Hy d oth	0						18. Mother	's Name	(First, Middle,				
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1 Separation   2 Command   3 Removal from State   Nichols   Bethel Cem.   May 14, 04   Odenton, Maryland   22 Name and Address of Facility   22 Name and Address of Facility   23 Name and Address of Facility   23 Name and Address of Facility   24 Name and Address of Facility   24 Name and Address of Facility   24 Name and Address of Facility   25 Name and Name and Address of Facility   25 Name and Name and Address of Facility   25 Name and N	is m													
Comment   Comm	im 27 her t	P						Court,			Mary	land :	2107	6
23a. Part Letter fid disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Immediate Cause) (Final Immediate)	if of h		the state of the s		Place of Dispo cemetery, cres	sition (Nam natory or otl	e of her place	)	D	ate	20c. Loc	ation - City	or Towr	n, State
23. Part Letter field disdays, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (final mediate). Such contents of the part failure. List only one cause on each line.  Sequentially list conditions.  Seq	tant:													
23a. Part I. Enter the defease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introductions and holes, or heart failure. List only one cause on anothine.  Madical Raminer  The part of the defease or injury and the part of the part	lmpo any ir		Velley	M00	113	LAII A	nnar	olls	Ka.	Odento:	n. Ma	atory arvla:	, P.	A. 1113
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Live birt	Medical kaminer prize pr	cai	Sequentially list conditions, if any leading to manufacture. There underlying Cause (Disease or injury that initiated events	b. <u>MPT 0 77 0 7 0 1 6 10 0 1 </u>	(to enhau)	LTEVI	në.	ias	rum	~~				
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24a. Was an autopsy performed? 1   Yes 2   No  25. Was case referred to medical examiner? 1   Yes 2   No  26. Place of Death (Check only one)  27. Manner of Death 1   Natural   5   Pending investigation   1   Yes 2   No  28a. Date of Injury (Month, Day Year)  28b. Time of Injury   28b. Time of Injury   28c. Injury at Work? 3   Suicide   4   Homicide   28c. Could not be determined   28c. Could not be	g pe	by	Part II. Other significant conditions	contributing to death but not res	sulting in the ur	nderlying cau	use giver	ı in Part I.		111	\			
25. Was case referred to medical examiner?	s bee	piet								24a. Was a	n	24b Were	autonev	findings avails
25. Was case referred to medical examiner?  1		E								perform	ned?	prior t death	o compl ?	etion of cause
1   Yes   2   No	rtifica tor. p	0	25. Was case referred to medical					26 Place of	f Dooth			1 🗆 Y	es 2L	] No
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and vittle of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	direc	0		Hospital: 1 Inpatient 2	ER/Outpatient	t 3□ DOA	Other					Other (Sr	necifu)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and vittle of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	fter th		A	28a. Date of Injury (Month. Day Year)			c. Injury a	ıt					ocny)	
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29a. Certifier (Check only one)  29b. Signature and vitle of certifier  29c. License number  29d. Date signed (Month, Day, Year)	s after de Il Directo Id in by t	Sertific	data-min-d	28e. Place of Injury - At h	ome, farm, stre	et, factory,	office		28	8f. Location (St. City or Town	reet and / i, State)	Number or i	Rural Ro	oute Number,
5-12-04	e Funera		[Once only Z[] medice CAdi	miles. On the basis of examina	owledge, death ation and/or inv	occurred at estigation, in	the time	, date and p	olace, an	d due to the ca	ause(s) ar ate and pl	nd manner : lace, and di	as stated	d. cause(s)
5-12-04	To th comp		29b. Signature and title of certifier			29c. 1	License r	number		25	9d. Date s	signed (Mo	nth, Day	, Year)
3-16-09				But M		T	751	CIT						
	Α Ι	-	30 Name and address of severe upo	completed cause of death (Item	1 23a) (Type F	Print)	<i>y y</i> \	- 1			2-	0-51	4	

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year HOWARI ,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner RE 176 STREE If Under 24 Hrs. If Under 1 Year 5, Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 224-48-544 12 M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MARJILAND 10e. Street and Number 10g. Citizen of What Country? 0 238 VETTE STREET USA Was Decedent Ever in U.S. Armed Forces? "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Infortant: if tiem 27 is marked other then "naturel", or its mortant: if tiem 27 is marked other then "naturel", or its my injury or other traumatic event, the Medical Examina 90.8. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+#GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 90 BALTO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of using, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bey een Ons Jan y eath Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a con uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Unknown 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? res 2000 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death Check on on Hospital: Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)
t 28d. I escribe how injury occurred 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check on Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signey (Month, Day, Year) who completed cause of death (Item 23 a) (Type, Print) A (Gulm 32. Registrar's Signargre State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 15522 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Josephine Μ. Bever May 2004 5:06 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Collington Episcopal Life Center Prince George's Mitchellville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year, Months 1 □ M 2 🗓 F Director 017-16-2162 82 Aug. 8, 1921 Maine Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b Count 7 is marked other then "natural", or items 23a or 28e-f show treumatic event, the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Rd. 20721 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other then "natural", or Itel Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Watts Morton Glavds Stackpole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any injury or other treun once. Christopher T. Bever, Jr./ Son | 4325 Conifer Ct.; Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 11, 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Chesapeake Crematory ` 4 ☐ Donation <sup>1</sup>5 ☐ Other (Specify) 2004 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services Tylod o Kumann M00382 933 Gist Ave., Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carcinano et the disease or condition resulting in death) 14000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): physician Box 68760. pe Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the Division of Vital Records, P.O. detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ phome 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death.
I Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MI 25 5/11/07 Que 12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place, Lanham 20 roty toblor orte mo 1-1 rol 31. Date filed (Month, Pey, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0  $\downarrow$ 15523 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8:40PM Brown MAN 2004 HORACE 0 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HODKINS Johns Hospital Ba Itimore he If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. las birthday) 5. Social Security Number 7. Age (In yrs. 9. Birthplace (State or Foreign **Funeral** 2 🗆 F 215 40 3240 Director MISSISSI Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a 28e-f show other traumatic event. The Medical Examiner must be notified at Yes 2 □ No **Funeral Director** HMUr CA 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with ò or items 23a U Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 2/2 No Specify: Specify Completed by 4 3 🗌 Widowed Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) Coltege (1-4or 5+) 15able0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hitem 27 Is marked oth W timeter nonie ð Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5431 Whitwood Re 1709 MAP Tene 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Buriai 2 🗽 Cremation 3 Removal from State ō Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 600 Spiro Mp 2/30 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardfac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DAY SEPSIS /Medical Due to (or as a consequence of) Examiner HTUGONIA PNEUMONIA Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed END-STAGE RINKL DISEASE 10 YEARS and Due to (or as a consequence of): Box 68760. attending physician Completed by Physiclan/Medical IMMUNODEPICIENCY VIRUS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Dav 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DAP VENIOUS THROMBOSIS 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an MALNUTRITION has page 2 autopsy certificate SCLEPOSIS 2 XNo MULTIPLE or Attanding Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 1 ☐ Yes 2√No 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funaral Diractor: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier RES-000 MAY 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOD NORTH WOLFE STREET, BALTIMOKE, MARRYLANDUZ87 ANANDI SHETH, JUHUS HOPKINS HOSPITAL

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

WAY 1 4 2004

32. Registrar's Signature

		For Amend Item 23a 1 - State Registrar		Maryland 5 <b>/14/04d</b>	d / Depa h <b>b</b> <i>Ce</i>	artmen rtificat	t of H e of L	ealth a Death	nd M			200	3. Time	521
Physici /Medic	al	1. Decedent's Name (First, Middle, Las  Mary E. Clelland		hash		4b City	Town or	Location of		2. Date of De Month May	Day 10	2004 County of De	3:00	
Examin Funeral	er	4a. Facility Name (If not institution, give Charlestown Retir 5. Social Security Number 6. Se	ement Co		ast birthday)		Caton	nsvil:	le	8. Date of Birt (Month, Da		Balt:		or Foreign
Director		210-07-1395  Usuel Residence of Decedent  10a. State 10b. County	□M 2 <b>2</b> F	84	Yrs.					12/16	5/191	19	PA 10d. Inside (	
the Maryli r 28e-f sho	Director	MD Baltimo	re		Cat	onsvi 10f. Zip					10g. Citi	zen of What		s 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral	709 Maiden Choice  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Lane 12. Was Deced Armed Ford 1 □ Yes 2 If Yes, Give Year or Date	ces? 2 <b>Z</b> No		Was Deced If Yes, spec	dent of Hi city Cuba	228 spanic Orig n, Mexican, Specity:	jin? (Spe , Puerto	ocify Yes or No Rican, etc.)		U.S.A.  14. Race - A. Black, W  Specify:	merican Indian, hite, etc. White	
d within 72 hours aft giene. er than "natural", or the Medical Exam	Completed by	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-	4or 5+)	(Give life.	dent's Usua kind of wo DO NOT us creta	rk done d se retired,	luring most	of worki	ng		nd of Busine	ŕ	
nd 2 should be filed in the and Mental Hygis 27 is marked other incumatic event, in	To Be Co	17. Father's Name (First, Middle, Last) Burton McBride	-			CICLA	ı y			(First, Middle,			11	
and 2 shoi salth and A n 27 is ma		19a. Informant's Name/Relationship (7			2415	01d	Fred	lerick	Rd.		nsvi	11e, M	D 21228	
Pages 1. ment of He ant: If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 🗹 Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify	)	iai <del>o</del>	lace of Dispo emetery, crea timore	/Wash	ingt	on 5	5/11,	-	Lau	rel, M		
permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		21. Signature of Juneral Service Licentary 22. Part 1. Enter the disease, or company	Tolor	eale	ン Vi	111e 1	630	Edmor	ndson	n AVe.	Cato		of Cato	1228
Physician /Medical Examiner but sugar physician and physician and street	ical Examiner	shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consequence or a	uavise of):	<del>- ()</del>	<del>} \                                   </del>	<del>K</del>	Strok	e			Initerval B Onset and	d Death
The law requires that the death certifica are has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	Ideath 3	⊒Ectopic pr ⊒ Other (sp					:	23d. Date of Month	delivery Day	Year
v requires that the bean signed by should be detact	ted by Ph	Part II. Other significant conditions of	ontributing to dea	ath but not resu	ulting in the u	enderlying c	ause give	en in Part I.		1	obacco u Yes 2		to the cause of	f death?
	Completed									1 ☐ Yes	osy ormod? 2 No	prior death		s available cause of
ding Phy n. After this funeral d	ation: To Be	25. Was case referred to medical examiner?  1  Yes No  27. Manner of Death Natural 5 Pending 2  Accident investigation	28a. Date of (Month)		ER/Outpatie 28b. Time o Injury	-	28c. Injury Work	or: 🙉 Nui	rsing Ho	n <i>(Check only o</i> me 5 ☐ Resid 28d. Describe I	dence		pecify)	
or At tter of Sirection by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place	of Injury - At ho g, etc. <i>(Specif</i> )	ome, farm, st	reet, factory	y, office			28f. Location (: City or Tox			Rural Route Nu	mber,
To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  Check only 2 Medical Exam		sis of examina						ed at the time,	date and	d place, and o	due to the cause	
To t To t	W	29b. Signature and title of certifier	<_	/ m		Ī	License	H H	)	,	29d. Dat	e signed (Mo	onth, Day, Year)	+
0			15, 71	11 No	, cla	Choi	Q	Lan	9	Caton	(S v.'	14	Mazle	f 4
Sta Regist		31. Date filed (Month, Day, Year) MAY 1 4 200	32/Re	egistrar's Signa	ture	Spa	els					~		

			1 - For State Registrar	State of Maryland / Do	epartment of I Certificate of			leg. No. 20(	14 1552
	hysici /Medic		1. Decedent's Name (First, Middle, Last)  John Cal	lvin Cra	mpton		2. Date of Dea Month May 11	Day Yeer	3. Time of Death  3:30 am M
	xamin		4a. Facility Name (If not institution, give s Kline Hospice Hou			or Location of Death	1	4c. County of Dec	
	neral ector		219-03-1200	M 2 F 7. Age (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sep 20,	1926 Mai	rthplace (State or Foreign country) ryland
Maryland	fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederic	ck 10c. City, Town	or Location erick				10d. Inside City Limits 1 🖾 Yes 2 🗆 No
vith the	or 28a De noti	Direc	10e. Street and Number		10f. Zip Code	701	1	10g. Citizen of What C	Country?
Q Z1Z15-0U36 filed within 72 hours after death with the Maryland Hygiene.	d other then "natural", or tame 23s or 28s-1 show event, the Medical Examiner must be notified at	Funeral Director	511 Magnolia Avenu  11. Marital Status  1 Never Married AMMarried	2. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 1 O / 5	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh	
5-003	dical Exa	eted by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	Year or Dates: 1946 ation completed)	1 ☐ Yes 2X No	pation during most of wor	kina	Specify:	White s/Industry
d within jiene.	the Mer	Completed	Elementary/Secondary (0-12)	0 11 (1 1 5 )	eliminary	d)		Printing (	Company
Maryland 21215-0036 Id 2 should be filed within 72 hours af th and Mental Hygiene.	marked othar than matic event, the M	To Be C	17. Father's Name (First, Middle, Last) $Claude \qquad \qquad L_{\bullet}$	Crampton		18. Mother's Nan Dora	ne (First, Middle, i	Maiden Sumame) Cro	one
	7 is trau		19a. Informant's Name/Relationship (Typ. Mrs. Lareaux W. Cri	-	Mailing Address (Street  1 Magnolia				· · · · · · · · · · · · · · · · · · ·
9 - ±	ant: If item 2 ury or other		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Re  1 4 □ Donation 5 □ Other (Specify)	cemetery.	Disposition (Name of crematory or other place vet Cemeter	су Мау 14	1	20c. Location - City o Frederick,	
Balt permit. Departr	Important: If it any injury or a		21. Signature / Euneral Service / Cerr e	MOO706  cations that caused the death. Do no	22. Name and Addr Keeney & 106 East ( t enter the mode of dy	ess of Facility Basford 1 Church St ng, such as cardiac	P.A. Funder: Freder:	eral Home ick, Maryl	and 21701 Approximate Interval Between
/Me	dician dical		Immediate Cause (Final disease or condition resulting in death)	Progressive non-		Lung car	cer		Onset and Death 4 months
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Metasasis to Bor Due to (or as a consequence of Due to (or as a consequence of	).				
68760,	g physicien and as the burial-transit	edical E	d						
BOX ath certi	ittending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	у		23d. Date of de Month	olivery Day Year
rds, P.	spen signed by the should be detached	by	Part II. Other significant conditions con Hypertension; Hy	tributing to death but not resulting in to percholesterolem:	, , ,	ven in Part I.	23e. Did tol	bacco use contribute i es 2 □ No 3 □ F	o the cause of death? Probably 4 Unknown
	ate has page 2	Completed					24a. Was a autops perform	ry prior to med? death?	utopsy findings available completion of cause of
f VII	this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	ospital: 1 Inpatient 2 ER/Outp	atient 3 DOA		th <i>(Check only on</i> ome 5 ☐ Reside		ecify) Hospice
DIVISION OF Il or Attending Phy after death.	Director: After the in by the funeral		27. Manner of Death  1 ★ Natural 2 Accident  2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Tir Inju	ury Wo	ry at rk? ]Yes 2 □ No	28d. Describe ho	ow injury occurred	
DIVISION Of VIEW To the Hospital or Attending Physician: within 24 hours after death.	filled in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	lural Route Number,
ne Hosp	To the Funel completely fil	Medical	(Check only one)	<ul> <li>iciam To the best of my knowledge, er: On the basis of examination and/ and manner stated.</li> </ul>	death securise at the to or investigation, in my	ino, date and place opinion, death occu	red at the time, d	ate and place, and du	stated. e to the cause(s)
To th withir	To the complex of the	Ň	29b. Signature and title of certifier	Zul	29c. Licen:	se number		9d. Date signed (Mon	
	1		30. Name and address o person who come P. Gregory Rausc		ype, Print)			May 11,	

State Registrar

Registrar MAY 1 4 2004

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

			For State Registrar	State of Ma	ryland /	-	artment of H				ene 3. No. 20 (	)4 1	5526
	Physicia		1. Decedent's Name (First, Middle, Last)	1 4					N	ate of Death Ionth	Day Ye	ar	ne of Death
	/Medic		Charles Ral				4b. City, Town, o	r Location		ay 12,	2004 4c. County of 0		00 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give s 2574 Riva Road, #8				Annapo		OI Death			Arundel	
-	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last b	irthday)	If Under 1 Year	If Under	24 Hrs. 8. D	ate of Birth	9.	Birthplace (Sta Country)	
	Director		214–44–1860	MM 2□F	60	Yrs.	Months Days	Hours	Ju	10nth, Day, 1 1y 12,	1943	Marylan	.d
	put A		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	ocation					10d. Insid	de City Limits
	Maryia f sho	ō	Maryland Anne Aru	ndel			napolis					1 🗆	Yes 2₹No
	28a-	rect	10e. Street and Number	III		7111	10f. Zip Code			10	g. Citizen of Wha	it Country?	
	h with	al Di	2574 Riva Road,	#8A			2	1401			USZ	A	
980	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? UNYes 2 N If Yes, Give Year or Dates:	lo	1	Was Decedent of H If Yes, specify Cub			res or No- n, etc.)		American India White, etc. White	
21215-0036	within 72 ho lene. 'than "natur ne Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5		(Ĝive life.	dent's Usual Occup kind of work done DO NOT use retire	during mos	st of working	11	6b. Kind of Busin		
121	e filed will Hygien other th		12th 17. Father's Name (First, Middle, Last)			Sa	lesman	18. Mothe	er's Name (Firs	st. Middle, Mi	Beer Sa	ares	
anc	0 to 0	o Be	Eugene M. Car	rr, Sr.					Anna D.		_		
Maryland	s 1 and 2 should be f Health and Mental item 27 Is marked othsr treumatic ev	၉	19a. Informant's Name/Relationship (Type		19	9b. Maili	ng Address (Street	and Numb	er or Rural Rou	ite Number,	City or Town, Sta	ite, Zip Code)	
	D = 2 :		Susan J. Carr/ Wife	e		2574	Riva Ro	ad, #8	8A, Ann	apolis	, MD 21	401	
nore,			20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		cemet	tery, crei	osition (Name of matory or other pla ans Cemet	1	Date 5-17-04	100	oc. Location - Cit Crownsvi		
Baltimore,	permit. Page Department o Importent: If eny Injury or once.		21. Signature of Funeral Service License	90	TID VC	2	2. Name and Addre	ess of Facili	ity Georg	e P. K	Kalas Fu	neral H	iome
	40500	$\sqcup$	23a. Part1. Enter the disease, or compli	cations that caused	the death. De		973 Solo					Approx	rimate
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	10.	e (	cances	-				Onset	Between and Death 4 Co. S
l.	Examiner	ıer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequenc	e oi).							
	icuted nd transit	Examin		:								-	
8760,	ate be executed thysician and the burial-transit		resulting in death) Last	d	a consequenc	e or):							
9	rtificate ng phys	Medi	IF FEMALE:										
O. Box	he death certific: the attending pl ched for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	; y			23d. Date of Month	•	Year
rds, P.O	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions cor	ntributing to death b	ut not resulting	g in the u	inderlying cause gi	ven in Part	l. :	23e. Did toba	acco use contribu	te to the cause	
I Records,		Completed								24a. Was an autopsy perform 1 🗆 Yes 2	prio dea	re autopsy find ir to completion th? Yes 2 \( \text{No.} \)	of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Otto Otto	hor	e of Death (Ch	1			-
of	Phys rthis ral dir	- T	1 ☐ Yes 2 No 27. and of Death	28a. Date of Inju	ry 28b	Outpatie 5. Time c	IK JUDON	4 🗀 14	lursing Home 28d.		nce 6 Other	(Specity)	
Division	Attending P	ation	1. Natural 5 Pending investigation	(Month, Da	y Year)	Injury	M 1	Yes 2					
Divis	s after de sel Direct	Certification;	3 Suicide 6 Could not be determined	28e. Place of Ini building, et	ury - At home, c. (Specify)	farm, st	reet, factory, office			ocation (Stre	eet and Number ( State)	or Rural Houte	Number,
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: Alier this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Phy Madical Exami	sician: To the best nar: On the basis o and manner st	f examination	lge, dea and/or ir	th occurred at the to envestigation, in my	ime, date a opinion, de	nd place, and o ath occurred at	due to the car the time, da	use(s) and mann te and place, and	er as stated. I due to the car	use(s)
	To the within To the Comp	W	29b. Signature and title of certifier	wew	- MO	)	29c. Licen	z 83	30		d. Date signed (MAY 12)		
	V		30. Name and address of person who co	empleted cause of o	death (Item 23)	a) (Type	Print) GAK Ro	ad #	300	Ann	apolis,	MDE	2140/
		ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature				,	,			
Dł	Regist		MAY 1 4 2004	Armera	<u>_</u>	1	only						

ORIGINAL

Patient Known as Cornelia Crudup

			Type or Print in Blact State of Maryland /			-	_	
	1	For State Registrar		Certificate of De	eath	Reg. No.	2001.	LEFOT
Physician		1. Decedent's Name (First, Middle, Las		ruduo	2.	Date of Death Month Day	Year	3. Time of Death
/Medical	L	Cornelia		rudup		May 12"	7 2004	8:438 M
Examiner	4	Ia. Facility Name (If not institution, give	street and number)	4b. City, Town, or Lo	thmore	City N	County of Death	
Funeral		5. Social Security Number 6. Se		pirthday) If Under 1 Year If	Under 24 Hrs. 8.	Date of Birth	9. Birthpl	ace (State or Foreign
Director	3	715-16-5914	DM 2127 90	Yrs. Months Days	Hours Min.	(Month, Day, Year) AR - Jul. 191	4 N. Car	Olina
and	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location			10	Od. Inside City Limits
Maryl Isho		MD NIA	Baltin	nore				1 Yes 2 □ No
with the Maryland a or 28a-f show be notified at Director	3	10e. Street and Number		10f. Zip Code			izen of What Count	try?
d 21215-0036  filed within 72 hours after death with the Maryland Hygiene.  ther then "natural", or litems 23a or 28a-1 show ant, the Madical Exercitivative incilling at a Completed by Funeral Director	3	2911 Ulman F	ive.	21215		US		
ifter death v	5	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specif Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - America Black, White, e	
036 urs aft		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No S	Specify:		Specify: Bla	ck
21215-003 ed within 72 hours ygiene. ner than "natural", t, the Modical Ext		15. Decedent's Ed (Specify only highest gra	ucation 16	a. Decedent's Usual Occupatio (Give kind of work done duri	on ing most of working	16b. Ki	ind of Business/Ind	ustry
Man vithin		Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		N	arsing Ho	me
ind 21215-0 be filed within 72 h tal Hygiene. d other than "natu event, if a Malcal Be Completed		17. Father's Name (First, Middle, Last)	141			First, Middle, Maiden		
Iryland 212- should be filed within an Mental Hygiene. marked other than imatic event, ItaM		Cephas Mitch	hell	L	illie	Walls		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours alt l'health and Mental Hygiene. tiem 27 is marked other than "natural; or other treumatic event, the Marical Estric To Be Completed by F		19a. Informant's Name/Relationship (7		9b. Mailing Address (Street and	4		or Town, State, Zip	Code)
C = 14 F	1	Ernestine Rees	e - daughter o	(Y) Ulman F. of Disposition (Name of	Ive. Bu	ilto., mo	2/2/5 ocation - City or Tov	un Ctata
altimore, mil. Pages 1 al ppartment of Hee portant: If tiem y injury or othe		20a. Method of Disposition  1 Burial 2 Cramation 3	Removal from State	ery, crematory or other place) Memorial Perk			dallstown.	
altim nit. Parantmen ortant: injury 9.	F	<ul> <li>4 □ Donation 8 □ Other (Specify</li> <li>21. Signature of Smeral Service Licen</li> </ul>	//	22. Name and Address of		14 KW16	dull Stown,	mo
Balt permit. Depart Import any inj sonce.	1	Smy All h	M	Gary P. March	F/H 2701	Fredhilton t	Pass Balto.	mo 21229
		23a. Part I. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.					Approximate Interval Between
Physician /Medical Examiner		Immedia(s Cause (Final disease r condition resulting in death)	a. Ruptvied Di Due to (or as a consequence	denial Au	rtie Ar	recysm		Onset and Death
	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of Circle yeards				
cuted nd ransit		cause. Enter Underlying Cause (Diseese or injury that initiated events	C					
0, e exec ian ar urial-tr		resulting in death) Last	Due to (or as a consequence	e of):				
68760, ifficate be example of physician as the burial ledical E	3	•	d					
S, P.O. Box 68760, es that the death certificate be exergined by the attending physician arbe detached for use as the buriat-thy Physician Amedical Examples		IF FEMALE:	23c. If yes, outcome of pregnancy				23d. Date of deliver	v
death cert	5	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				Day Year
P.O. that the de by the detached	1130	9 🗆 Unknown	9⊡ Unknown					
S, F res that signed be de	5	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in	in Part I.	23e. Did tobacco u	use contribute to the □ No 3 □ Proba	
I Record: The law require rate has been signage 2 should be completed.	2					77. A		
Rec	1					24a. Was an autopsy performed?	prior to con death?	sy findings available pletion of cause of
Vital Records, sicien: The law requires the certificate has been signed irrector, page 2 should be to Be Completed by		25. Was case referred to medical		26	6. Place of Death (C	1 Yes 2 No	1 ☐ Yes	25 No
on of Vital Ruding Physicien: The International director, page funeral director, page flon: To Be Comition:	ן נ	examiner? 1 ☐ Yes 25€ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Othor		5 Residence	6 ☐Other (Specify)	)
ng Ph fter th ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 28b (Month, Day Year)	. Time of 28c. Injury at Work?	280	d. Describe how injur	y occurred	
Division of or Attending Physical death.  Director: After this in by the funeral director. Teerification: Teeri	2	2 Accident investigation 3 Suicide 6 Could not be			3 2 No	. Location (Street an	rd Mumber or Durel	Davida Mumbas
Division control of the control of t		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	201	City or Town, State	)	noute rainber,
Division of Vital Records, P.O. Box 68760,  To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transity Medical Certification: To Be Completed by Physician/Medical Examilians.			ysician: To the best of my knowled liner: On the basis of examination a and manner stated.					
To th within To th compl	- 12	29b. Signature and title of certifier	71.	29c. License nu	umber	29d. Dat	te signed (Month, E	Day, Year)
		> (Edural X	WH M.D.	D0056	1383	5/	12/04	
3		30. Name and address of person who	completed cause of death (Item 23a	Sinai H	ospital	of B	altimo	re
State Registrar		31. Date filed (Month, Day, Year) MAY 1 4 2004	32. Registrar's Signature	Sports				

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** May 0 0 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner TIMORR Ce/ 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Feb 5, 1949 9. Birthplace (State or Foreign Social Security Number 6 Sex **Funeral** Months Days Hours Maryland 102M 2□ F 55 Yrs. 216-52-7688 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Is marked other than "natural", or itama 23a or 28a-f show sumatic event, the Madical Examinar must be notified at 1 Pres 2 □ No Baltimore Directo N/A MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21239 United States 1293 Limit Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: 69 – 70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify:Black Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Postal Service Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nt of Health and Mental Hit: If item 27 is marked oth Be Olivia Matthew Mosby Horace Elwood Cromwell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1293 Limit Avenue, Baltimore, MD 21239 Mrs. Gladys Cromwell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition May 14 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Beltsville, MD 2004 Chesapeake Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) Puneral Service Ligense 21. Signatura 22. Name and Address of Facility Cremation and Funeral Alternatives 1100984 8717 Green Pastures Drive Baltimore, MD 23a. Rart1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to Necrotizing Physician aug /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown s been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1□ Yes s after death.

I Director: After this certificate in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 X npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔊 No 3 DOA 2 FR/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 2 No 1 Tyes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Sign U 0 of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Paven Blvd Baltimore MD 2123 32 Registrar's Signetture State Registrar

Patient Known As Yelizaveta Dynina

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1- State Registra AMEND TIEM #9 PER Fh 9831 5/14/04 JIC ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DYNINA 10:15AM YELIZAVETA Mau 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital of Baltimore Citu Baltimore N/A 9. Birthplece (State or Foreign DELLARUSE If Under 1 Year | If Under 24 Hrs. B. Date of Birth MAR. 21, 1921 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 👿 F 83 Yrs. 217-25-9443 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "netural", or itams 23a or 28a-f ehow 1 Yes 2 No Director BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 829 JOSHUA TREE COURT 21117 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ie markad other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ DOCTOR PEDIATRICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental (UNKNOWN) SAMUEL GOLDIN **ETKA** ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Importent: If item 27 is
any injury or other treu 986 JOSHUA TREE COURT - OWINGS MILLS, MD 21117 EMILIA DYNINA / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 5/13/2004 REISTERSTOWN, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a, Part1. Enter the diseas shock, or heart failure. , or complication List only one cau Immediate Cause (Final Amoxic **Physician** Encephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renal Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit 2513 that initiated events resulting in death) Last Due to (ou s a consequence of): certificate be exec Division of Vital Records, P.O. Box 68760 the attending physician Disease Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the all d be detached for 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by (Ventilator Dependence 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death

1 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours ix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12,2004 May 1000 30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print) MO Linai 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2004 MAY 1 Registrar

Daniels, Alphonso

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 9:50 **Physician** 12 2004 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel HOSPITGI Burnie 6160 Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 213-48-0346 Usual Residence of Decedent 50 Yrs. Director 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28e-f show other treumatic svent, the Mydical Examiner must be notified at 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Married Yes 2 □ No Yes, Give Year or Dates: 1 Never Married 1 Yes 2 No Specify: RIACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then 17. Father's Name (First, Middle, Last) 19b. Mailing Adjess (Street and Number or Rural Route Number, Informant's Name/Relationship (Type Kardalstrum MD21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of injury or 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee andustown, MU 21182 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. noverti tmmediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to ras a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25 No 1 Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No P 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Aatural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 T Homicide within 24 hours a To the Funerel 6 turcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19-17 G 7 31. Date filod (Month, Day, Year) 32. Re Registrar's Signature State Registrar MAY 1 4 2004

			1 - For State Registrar	state of Ma	aryland		artment e tificate			ind M		giene	2004	15531
2	Physici	an	1. Decedent's Name (First, Middle, Last)  Margaret Murie	el Evans							2. Date of Dea Month May 13	Day	∩4 Year	3. Time of Death 12:30 a <sup>M</sup>
	/Medio Examin		4a. Fecility Name (If not institution, give stre 2204 Snydersburg Ro	et and number)			4b. City, To		ocation o		ray 13		ounty of Deat	h
	Funeral Director		5. Social Security Number 6. Sex		e (In yrs. las 87	t birthday) Yrs.	If Under 1 Months [	Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day Jun 16,	h Y, Year) 1916	Co	nplace (State or Foreign untry) yland
	Maryland -f show fired at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll		10c. City,	Town or Lo	cation	ŀ	Hamps	tead				10d. Inside City Limits 1 ☐ Yes 2∑ No
	with the	i Director	10e. Street and Number 2133 Albert Rill Ro	oad			10f, Zip C	ode	2	1074	1	10g. Citize	on of What Co USA	untry?
336	d within 72 hours after death with the Maryland Jiene. rithan "natural", or Items 23a or 28a-1 show the Medical Evandurer must be motified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Deceder f Yes, specify		oanic Orig Mexican Specify:	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		I. Race - Ame Black, White pecify:	
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)			(Give life. l	lent's Usual ( kind of work of NOT use OUSEW1	done du retired)	on ring most	of worki	ng		of Business/	,
yland 2	be filed tal Hyg d otherwent,	To Be Co	17. Father's Name (First, Middle, Last)  Robert S. McLaren					1			(First, Middle, e A. Si		umame)	
	nd 2 sh lith and 27 is rr r traurr		19a. Informant's Name/Relationship ( <i>Type</i> , Linda Wedge, daught								Route Numbe Westmi	-		
altimore,	Pages 1 and the sound of the so		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	cem	netery, cren	sition (Name natory or othe M Ceme	ir place)	- 1		/2004		ation - City or '	
Balti	permit. Pages. Department of the Important: If ite any injury or of pages.		21. Signature Feral Service Licensee	FC	M00723	3 22	. Name and	Address	of Facility	/	Eline F Hampst	unera	al Home	2
	Physician /Medical Examiner	iner	23a. Part1. Enfer the disease, or complicat shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ause on each lir	divo	us aul	ř	of dying.	such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
x 68760,	death certificate be executed e attending physician and of for use as the burial-transit	/Medical Examiner	resulting in death) Last  d  IF FEMALE:	Due to ras	onsequer of pregnance							222	d. Date of deli	100
P.O. Box	at the death by the atten tached for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic preg Other (spec					23	Month	Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contrib	outing to death bi		/ 1		-		<i></i>		bacco use es 2,47		the cause of death?
Vital Records,	The ate h page	Completed	Moude degen	vatin	, ()	Pepres	Son				24a. Was a autop: perfor 1 Yes	med?	24b. Were au prior to d death? 1 ☐ Yes	lopsy findings available ompletion of cause of 2 No
o	ling Phys I. After this Tuneral di	atlon; To Be	1 Natural 5 Pending 2 Accident investigation	oital: 1 □ Inpatie 28a. Date of Injui (Month, Day	v 28	VOutpatien  Bb. Time of Injury		Other: Injury a Work?	4 □ Nur	sing Hor	(Check only or ne 5 ☐ Resid	ence 6	daught Ther (Spec occurred	er's home
Division	ital or Attenors after deathral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ury - At home c. (Specify)	e, farm, stre	eet, factory, o	ffice		2	8f. Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical	29a. Certifier La Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of On the basis of and manner sta	examination	edge, death n and/or inv	occurred at restigation, in	the time, my opin	, date and non, deat	f place, a h occurre	and due to the coord at the time, o	ause(s) ar late and pl	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier  U	eller	,m	Vþ.	P	-07	SVI.	21	2		Signed (Month	•
	V		30. Name and address of person who comp	R RD S	STE 32	3а) (Туре, I 20 <i>t</i>	FINES B	ukl	, My	21	ov8	7	HIVSON	N DELLOSA, A
7	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	4 1	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ELLISON JOYCE MAE 00° /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BUTINOCE
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) TT.Y 4, 1924 N/A 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2√□ F Yrs FLORIDA 577-34-2906 79 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show event, the Medical Examiner must be nutitied at 1XYes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 10 N. ROCKGLEN ROAD 21229 U.S.A. Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2XXVo Specify Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 2008. Be FLOWERS MAE SHIRLEY GEORGE Μ. ADA ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18112 ALT STREET, SPRINGHILL, FLORIDA 34610 GEORGE PEARCE/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 5/15/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 032/00 Growi /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examiner cause (Disease or injury that initiated events resulting in death) Last burial-transit that the death certificate be executed Due to (or as a consequence of) use as the Box ( IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Yes 2 □ No Year Month Day 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably Unknown 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy certificate 051 1 Yes Vital Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1XYes 2□No this ō 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death, To the Funerel Director: A death. investigation 2 Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 36. N, me and address of person who completed cause of death (Item 23a) (Type, Print) 2003 O. 32. Registrar's Signature Date filed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 1/2001

MAY 1 4 2004

Monday, May 10th 2004 @61SP
Baltimore Maryland 21215-0036 GAGAN, JAMES 5-10-04@ 1815

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		•	For State Registrar					cate of L			Reg. N	200	4 15533
		_	1. Decedent's Name (Fi	īrst, Middle, Last,	}					2. Date of D Month		ay Year	3. Time of Death
	Physicia /Medic	al	James K.	Eagan	, 111				1	May 1	-	2004	6:15 P
	Examin	er	4a. Facility Name (If not			7)			Location of Death			lc. County of De	
	Funeral		Gilchrist 5. Social Security Numb	ber 6. Se	x 7. A	ge (In yrs. last bir	thday) If L	WSON Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of B	irth	Baltime	rthplace (State or Foreign
	Director		079-34-89	707	<b>M</b> 2□ F 6	1	Yrs. Mo	nths Days	Hours Min.	Mar.2		943 ME	
	and W		Usual Residence of Dec 10a. State 10	b. County		10c. City, Tow	n or Location	า					10d. Inside City Limits
	Maryll f sho	tor	MD	Howar	d	Colum	nhia						1 ☐ Yes 2 🗖 No
	ours after death with the Marylan rel', or Itema 23a or 28a-f show Exertir et must be notified at	Director	10e. Street and Numbe					of. Zip Code			10g. (	Citizen of What (	Country?
	th wit	aiD	11309 Rid	dermark				21044				USA	
	er dea	Funerai	11. Marital Status	O/TEN de min el	12. Was Deceder Armed Forces	\$?	13. Was I	Decedent of Hi , specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Hace - An Black, Wh	nerican Indian, ite, etc.
3	irs after	by F	1 Never Married 3 Widowed 4		1 ☐ Yes 2 <b>X</b> If Yes, Give Year or Dates	:	1 🗆 Y	es 🗶 No	Specify:			Specify:	white
	72 hours naturel', Jical Em		15. (Specify)	i. Decedent's Edu	ication	16a	. Decedent's	Usual Occupa	ation during most of work	rina	16b.	Kind of Busines	s/Industry
7	ithin 7	Completed	Elementary/Seconda		College (1-4o		life. DO N	OT use retired	)	J		,	_ ,Real
4	filed within 72 hours after death with the Maryland Hygiene. Wher than "naturel", or Itema 23a or 28a-1 show ant, the Medical Exactinat must be notified at		17. Father's Name (Firs	st. Middle, Last)	5+	Lav	vyer		18. Mother's Nam	e (First, Midd		eneral en Sumame)	Law/Estate
<u> </u>	2 should be filed within n and Mental Hygiene. is marked other than reumatic event, the Mental matter than reumatic event, the Mental matter than a matter than the matter t	To Be	James K.		Jr.				Margare	et Max	ine	e Grady	
2	2 shou and M is mar raumati	<b>—</b>	19a. Informant's Name	e/Relationship (T	ype, Print)	1	_		and Number or Rui	al Route Num	ber, Cit	y or Town, State	Zip Code)
Š	s 1 and 2 should be filed withi f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M		Lindell E		ife				nark Rov				
	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposi 1 Burial 2 C 4 Donation 5	Premation 3 □	Removal from Stat	(e	ry, cremator	y or other plac		Date 3 / 2 0 0 4		Location · City i	
Dall	permit. Departn Imports any injt		21. Signature of Funer	ral Service Licens	202				<sup>ss of Facility</sup> Wit n Knolls				mes, Inc. Md. 21045
, e			23a. Part1. Enter the c	disease, or comp	lications that caus	ed he death. Do	not enter the	mode of dyin	g, such as cardiac	or respiratory	arrest,	- · · · · · · · · · · · · · · · · · · ·	Approximate Interval Between
1	Physician		Immediate Cause (Findisease or condition	nal	a. L	Ung	CAN	ncer					Onset and Death Month
	/Medical Examiner		resulting in death)		Due to (or a	as a consequence	of):						
L	<b></b>	er	Sequentially list condit if any, leading to imme	ediate 📕	b. Due to (or a	as a consequence	of):						
	and -transit	aminer	cause (Disease of inju- that initiated events	ing ury	C							_	1
Š,	e exec	ŵ	resulting in death) Las	st .	Due to (or a	as a consequence	of):						
00/00	certificate be executed Iding physician and Ise as the burial-transi	dica			d								
מממ	w requires that the death certificate be execut been signed by the attending physician and should be detached for use as the burial-trat	Physician/Medical	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outcom							23d. Date of	lelivery
0	death e atte	icia	in the past 12 mo 1 □ Yes 2 □ N	onths?		2 Fetal death		ppic pregnancy er (specify)				Month	Day Year
г Э	at the	Phys	9 Unknown Part II. Other significa				in the under	wing cause an	on in Part I	23a Die	1 tobacc	o use contribute	to the cause of death?
	requires that the death een signed by the atter nould be detached for u	ρ	1 ive		ruhos		in the driden	ying oddso giv	off at t att.	1	_		Probably 4 Unknown
ŝ	J _ =									04- 146	20.00	24b. Were	
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Records,	fhe law req te has beer age 2 shou	omplete								au pe	topsy rformed	? prior ! death	o completion of cause of
T E	The lay ate has page 2	3e Completed	25. Was case referred	to medical					26. Place of Dea	au pe 1 ☐ Yes	topsy rformed 2	? prior ! death	o completion of cause of ? es 2 No
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or vital Re	spital or Attending Physician: The lavours after death.  Neral Director: After this certificate has filled in by the funeral director, page 2	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certitier (Check only one)	5 Pending investigation 6 Could not be determined  A Certifying Ph Medical Exam	28a. Date of line (Month, 28a. Place of building, 28a. Place of building, 28a. To the besiner: On the basis	Injury - At home, to etc. (Specify)	Time of Injury  farm, street,	28c. Injur Wor Al 1 Gractory, office	er: 4 Nursing H y at k? Yes 2 No ne, date and place pinion, death occu	au pe 1 Yes th (Check only ome 5 Re 28d. Describ 28f. Location City or 1 and due to time and due to time at the time 1	topsy formed 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Prior i death 1 Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	o completion of cause of res 2 \( \text{No} \)  Decify) \( \text{O Spice} \)  Rural Route Number,  as stated, ue to the cause(s)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 4 2004

Sparks

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 200Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 7, **Physician** 2004 11:45 A.M Donald Harry Fox, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 8744 Indian Springs Road If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) OCt. 18, 1919 9. Birthpiace (State or Foreign 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 11☑M 2□F Maryland 220-05-6350 84 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, in Medical Exemplical Exemplical Exemples rediffed at once. 1 ☐ Yes 2 ☐ No Maryland Frederick Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 U.S.A. 8744 Indian Springs Road Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Supervisor U. S. Government 18 Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elsie Mae Wenzel Warren Garfield Fox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8744 Indian Springs Road, Frederick, MD 21702 Louise A. Fox/Wife 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 -Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery May 11, 2004 Frederick, MD \* 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee M00021 Keeney and Basford Funeral Home Khar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest rederick, in the shock, or heart failure. List only one cause of each line. 23a. Part1. Interval Between ine (1) Immediate Cause (Finat disease or condition Due to (or as a posequence of): Pnysician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physicien and thed for use as the buriat-transit and r that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à **6**9 1 4 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1□ Yes 2☑M Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA P 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred in by the funeral 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospitel within 24 hours a To the Funerel L 1 Certifying Phystcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of death (Item 23a) (Type, Print) 30. Name and address of 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State o	f Marylan		artmen			nd Me		giene Reg. No.	200	+ 1553	5
	_		Negistrar     Necedent's Name (First, Middle, Lass)	t)						2	. Date of Dea	ıth	.,	3. Time of Death	
	Physicia	an		Fritte	er						Month May	11 <sup>Day</sup>	2004	5:55P M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City,	Town, or	Location of	f Death		4c.	County of Death	1	
	Examili	EI	NorthHampton M	anor			Free	deri	ck			Fr	ederic	k	
	Funeral		Social Security Number 6. S	ex	7. Age (In yrs.	last birthday)	If Under Months		If Under 2 Hours	24 Hrs. 8 Min.	Date of Birt	h ( Year)	9. Birth	place (State or Foreign	
	Director		120-12-2672	□M 2 <b>%</b> F	83	Yrs.	Worth	Days	1100.0		09/05	/19	20 Mar	yland	_
	D .		Usual Residence of Decedent  10a. State 10b. County		10c Cit	v. Town or Lo	cation							10d. Inside City Limits	-
	arylai ehov	_		-1-										1 ☐ Yes 2 No	
	8a-f	ecto	MarylandFrederi 10e. Street and Number	CK	Net	w Mar	10f. Zip	Code				10a Citi	zen of What Co	untry?	-
	with the	ä	10304 Huron Co	11 m t			217					-	ted St		
	s 23	Funeral Directo	11. Marital Status		edent Ever in U	.S. 13.	Was Deced	dent of Hi	spanic Orio	gin? (Speci	fy Yes or No		14. Race - Ame	ncan Indian,	—
	Item Item	Ę.	1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐ Yes	orces? 2 No		fr Yes, spec	city Cubar	n, Mexican.	, Puerto Ri	can, etc.)		Black, White	e, etc.	
38	irs af	þ	3 Widowed 4 □ Divorced	If Yes, Gi Year or D	ve		1 🗌 Yes	2 No	Specify:				Specify: Wh	ite	
5-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Medical Examinar must be notified at	ted	15. Decedent's Ed	lucation	·	16a. Dece	dent's Usua	al Occupa	ition	of working	,	16b. Ki	nd of Business/	ndustry	
215	hin 7.	ple	(Specify only highest gra	College (	1-4or 5+)				)	of working				+ G+	
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pu	al Hy al Hy 1 oth	Be	17. Father's Name (First, Middle, Last)								First, Middle,	Maiden	Sumame)		
yla	Ment Ment arka atic	2	Martin Jacob			T				Thl			T 0000	To Contain	
Maryland	2 sh and is m		19a. Informant's Name/Relationship (	Type, Print)			-						r Town, State, 2 Mary 1	and 21774	
	l and lealth im 27		JoAnn Zboyan  20a. Method of Disposition		20b. l	Place of Dispo	osition (Nar	ne of		Da			cation - City or		_
0	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiens.  If item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at		1 ☐ Burial 2 ☐ Cremation 3 ☐			cemetery, cre	matory or c	ther place	e)	5/17	/200			, Marylan	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event, Ina Magnee.		4 □Donation 5 □Other (Specif		Da	<del>-</del>									
Bal	Deparent Dep		2) Signature of Futieral Service Col	4/1									omes P		
	-		23a. Part1. Enter the disease, or com	plications that	caused the dea	th. Do not en	ter the mod	de of dying	nest g, such as	er S cardiac or	respiratory a	Ba. rest,	Itimor	e, MD 2123 Approximate	-
			shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.									Onset and Death	
	Physician / Medical		disease or condition resulting in death)		Or as a consec		_							lomos	
	Examiner				(0) 20 2 0011000	400.100 0.7.									
	45.	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):									
	outed id ransit	Examiner	that initiated events	c											
0	be execuician and burial-trai	EX	resulting in death) Last	Due to	(or as a conse	quence of):									
8760	cate be executed oblysician and the burial-transit	ical		d									-		
9	eath certifica attending pl	Med	IF FEMALE:			Later.								. =	
Вох	attend for use	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregn birth 2 ☐ Fet	at death 3	Ectopic p						23d. Date of del Month	ivery Day Year	
0.	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time of a nown	death 5	Other (s	оеспу)							
٥.	that the de ed by the detached		Part II. Other significant conditions	contributing to	death but not re	sulting in the	underlying (	cause give	en in Part I.		23e. Did t	obacco u	ise contribute to	the cause of death?	
of Vital Records,	signed I	d by									10	Yes 2	ØNo 3□Pr	obably 4 Unknown	1
Ö	v requir been s	ete									24a. Was	an	24b. Were au	itopsy findings available	 a
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a		e Co	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o	2 No	T Tes	2   NO	_
Ş	ysician: is certific director,	To B	examiner?	Hospital:	Inpatient 2	] ER/Outpatie	nt 3 D	OA Oth	4				6 □Other (Spe	cify)	
o	유무등		27. Manner of Death		of Injury oth, Day Year)	28b. Time		28c. Injun Wor			8d. Describe				_
ion	Attending I death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation		min, buy roury	injury	М		Yes 2	No					
Division	er death	Certification;	3 Suicide 6 Could not to determined	289. Flac	e of Injury - At I	nome, farm, s	treet, factor	y, office		28	8f. Location ( City or To			ural Route Number,	
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	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical	(Check only 2 Medical Exa	miner: On the	ne best of my kr basis of examin	iowledge, dea ation and/or i	th occurred nvestigation	at the tin n, in my o	ne, date an pinion, dea	nd place, ar ath occurre	nd due to the d at the time,	date and	and man <i>n</i> er as place, and due	s stated. to the cause(s)	
	thin 2 the mptet	Med	29b. Signature and title of gentities	and ma	nner stated.		29	c. Licens	e number			29d. Da	te signed (Mont	h, Day, Year)	_
	To To Con		6(1)	DAMA A	nd			0)4	0307	7		5	13-0	4	
	Ín		30. Name and address of person who	completed car	use of death (Ite	m 23a) (Type	, Print)								-
	Y		1564 Oppossu	ntour	Pike	2 Fre	den	ck	MD	2170	02,	E.C	asagr	ande	
5		ate	31. Date filed (Month, Day, Year)	Ø32.	Registrar's Sign	ature	de								
	Regist	rar	MAY 1 4 200	7 1000	1										

	•	For Amend Item 23a p	er Dr.,Gooi,	,W/14/W	ertificat	e of L	Death			Reg. No.	004	15536
		1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
Physici /Medi		Harvey Roy Fischma	ın						May 13			6:15 p M
Examir		4a. Fecility Name (If not institution, give s			4b. City,		Location o				ty of Death	
		Broadmead Health C			14 1 1 2 2		Cocke				imore	
Funeral Director		067-12-8015	M 2□F 7. Age	(In yrs. last birthda 84 Yrs.	y) If Under Months	Days	Hours	Min.	8. Date of Birt (Month, Da Oct 30	y, Yeer)		place (State or Foreign intry) York
pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
Maryli f eho	ō	MD Baltimore	e	Cockeys	ville							1 ☐ Yes 2 ☑ No
the 28a	Director	10e. Street and Number			10f. Zip	Code				10g. Citizen o	f What Cou	intry?
3a or	ā	13801 York Road			210	30				United	Stat	es
death ms 2	Funeral	11. Marital Status	2. Was Decedent Ev Armed Forces?	ver in U.S. 1	3. Was Dece	dent of H	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 14. R	ace - Ameri	
within 72 hours after death with the Maryland iene. iene. "han "natural", or Items 23e or 28e-f ehow Ite Medical Examinan must be notified a	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 Yes		_		110411, 010.7	Spec		
72 hour	ted	15. Decedent's Educ	cation	16a. De	cedent's Usu	al Occup	ation	t of working	na	16b. Kind of		
ad within 72 hours aff giene. er than "natural", or the Medical Exami	ple	(Specify only highest grade	College (1-4or 5+		DO NOT u	se retired	1)	i Oi WOIKII	ng .	Resear	ch/Jo	hns
	Completed		5+		ernari	an/P						versity
be filed ital Hygid of other event, L	Be (	17. Father's Name (First, Middle, Last)							(First, Middle,		ame)	
	2	Abraham Fischman							le Chur			
d 2 should th and Mer 7 ie marka traumatic	1 9	19a. Informant's Name/Relationship (Type				,			I Route Number			ip Code)
		Ms. Alice H. Rodma	in/Compani	On 313			enue,		timore,	MD 21		own State
Se to L		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R.	emoval from State	cemetery,	rematory or	other plac	(e)		ay 15			
men tent: jury		'4 □Donation 5 □ Other (Specify)		Chesape	_				004	Beltsv	ille,	MD
permit. Page Department Importent: Il any injury o		21. Signature of Funeral Service License	11 _ 1	DPPOOL		tion	and	Fune	ral Alt			
00200	M. A	23a. Partf. Enter the disease, or compli	On the second of	the death. Do not					s Drive		imore	Approximate
Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	re cause on each line	NAL	FA	12	URE	) []				Interval Between Onset and Death
/Medical Examiner		resulting in death)	,	consequence of):								,
Examines		Sequentially list conditions b		rtension								
sit ed	line	Saguar Many list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or,								
and and III-tran	Examiner	that initiated events resulting in death) Last		consequence of):								
death certificate be executed e attending physician and for use as the burial-transit	ical E											
icate physics the		0										
leath certifical attending phi of for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of							23d. (	Date of deliv	very
atter of for u	clar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 □Ectopic p 5 □ Other (s,		/ 			1	Month	Day Year
that the de led by the a	hys	9 Unknown	9 Unknown									
es De de	b	Part II. Other significant conditions con	tributing to death bu	t not resulting in th	e underlying	cause giv	en in Part I	l.	23e. Did t	_/	·	the cause of death?
w requir been s should	ete	[ andsturi	1/1/200	-L DI.	10	/ /			24a. Was	an 241	b. Were aut	opsy findings available
The law cate has I	Completed	Ongoine	HUSI	1 01.	NO Y					rmed?	death?	ompletion of cause of
		25. Was case referred to medical					26 Place	e of Death	1 ☐ Yes	2 1 No	1 🗆 Yes	2 No
Physician: this certific ral director,	o Be	avaminar?	lospital:	nt 2 ER/Outpa	tient 3 D	Oth	or /		me 5 ☐ Resi		other (Spec	n(v)
Physician: T ir this certificat ir al director, pa	11-	27. Manny of Death	28a. Date of Injury (Month, Day			28c. injur Wor			28d. Describe			
th. Afte	tlor	1 Platural 5 Pending 2 Accident Investigation	(Month, Day	Yeer) Inju	M		1Κ? Yes 2 🔲	No				
or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm . (Specify)	street, factor	y, office			28f. Location ( City or To	Street and Nu wn, State)	mber or Ru	ral Route Number,
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,		(Check only 2 Medical Exemi	sician: To the best oner: On the basis of	examination and/o	eath occurred r investigation	at the tir	me, date ar	nd place, a	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
the I the I	Medical	one)	and manner stat	ted.	20	c. Licens	e number			29d. Date sig	ned (Month	, Day, Year)
To To	-	29b. Signature and title of certifier	6	11/ 7/	16	7	200	00		21	1,,11	a mil
		Dawars	Land	we It	2	110	000	10		0/	17/	1004
10		30. Name and address of person who co	impleted cause of de	12 (11 ) (Ty	Pe, Print)	RT	CA	CNE	1/1/11	IF X	10	21131
	ate	31. Date filed (Month, Day, Year)	32. Begistra	r's Signature	VUNN	110	100	ノハレ	4011	vy'	1)	JUSU
	trar	**** 4 4 200	1 Sene	va &	An	ne Va	/					

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			1 - For State Registrar	Otate of W	iai yiai i			te of D			Reg. No	200	11. 1	550-
			Decedent's Name (First, Middle, L.	ast)						2. Date of De Month			3. Tin	ne of Death
	Physici Medio/		Clementine H	ettie Fra	zier		,			May 12	2, 20	004	8:	21 AM <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, gi		r)				ocation of Dea	th	40	. County of E	eath	
E.	uneral		34 Love Run Roa 5. Social Security Number 6.		ige (In yrs.	last birthday)	If Und		f Under 24 Hrs	8. Date of Bir	th	Cecil 9.	Birthplace (St	ete or Foreign
	irector		234-34-7240	1 □ M 2 💢 F	78	Yrs.	Month:	Days	Hours Min	. (Month, Da			Country) irginia	
and	ž		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				•			de City Limits
Maryl	-fehc Egg	tor	Maryland Cecil		CC	olora							10	Yes 2 No
th the	or 28a e ngill	Director	10e. Street and Number			JIOIU	10f. Z	ip Code			10g. Cit	tizen of What	Country?	
death with the Maryland	ust b	ral	34 Love Run Roa					21917				USA		
after de	ltems Instru	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Deceden Armed Forces 1 □ Yes 2 5	?	S. 13.	Was Dec If Yes, sp	edent of Hisp ecify Cuban,	anic Origin? (: Mexican, Pue	Specify Yes or No rto Rican, etc.)	)-		merican India /hite, etc.	ın,
hours at	E E	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	-		1 🗌 Yes	2 <mark>∑</mark> No	Specify:			Specify:	White	9
<b>7</b> 2 ho	rthan "natural", or Items 23a or 28a-1 show the Medical Examiner must be notified at	Completed	15. Decedent's I (Specify only highest g	Education rade completed)		(Give	kind of v	ual Occupati vork done du	on ring most of wo	orking	16b. K	and of Busine	ss/Industry	
within 72 ene.	than the Me	дшо	Elementary/Secondary (0-12)	College (1-4o	r 5+)			use retired) e Opera	ator		<b>സ</b> രി ദ	nhone	Commin	nicatio
8 6	d other event, t	Be Co	17. Father's Name (First, Middle, Las	st)		10101	J1011			me (First, Middle			Carrena	TICACIO
aryiand should be file		ToE	Arthur (nmn)	Blevins					Nanny	May E	laga			
Mar d 2 sh th and	tem 27 le marke other traumatic		19a. Informant's Name/Relationship		•		-			Pural Route Numb	-		e, Zip Code)	
Heal	tem 2		Agnes A. Brewer 20a. Method of Disposition	/ Daungter	20b. F	lace of Dispo	sition (N	eme of	aa, cor	ora, MD			or Town, Ste	te
Dalltimor permit. Pages Department of	nt: If		Burial 2 Cremation 3		e	emetery, cree Ford N			ardens	5-15-04	Δhe	erdeen	Mary	land
Dailt permit. Departm	Importe any inju		21. Signature of Funeral Service Lice	ensee	1101					iome, P.A		<u>JI UCCII</u>	, PRILY-	Lana
<b>1</b> 85	E = 8		Steple al	Hugh		1	L317	Cokesl	oury Ro	ad, Abir	ador	n, Mar		
			23a. Part . Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final				ter the m	ode of dying,	such as cardia	ic or respiratory a	rrest,		Onset	il Between and Death
	sician edical		disease or condition resulting in death)	Due to (or a	n tu								9,	menths
Exa	miner		Conventially that conditions	b		30.700 07,								
p	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a conseq	uence of):								•
/60, le be executed	and al-tran	Examiner	that inflated events cesulting in death) Last Due to (or as a consequence of):											
Poor	attending physicien and for use as the burial-transit	calE	d											
ntifical	ng ph	Medi												
The law requires that the death certifica	attendi for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	I death 3		pregnancy				23d. Date of Month	delivery Day	Year
इ	y the a	nysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4☐Pregnant 9☐Unknown		eath 5L	Other (	specпу)						
S that	signed by the a Id be detached f	by Pt	Part II. Other significant conditions			ulting in the u	inderlying	cause given	in Part I.	23e. Did 1	obacco	use contribut	e to the cause	e of death?
oguire equire	been sig	ted	Deep venou	5 thromb	0515				***************************************	1 🗆	Yes 2	□No 3□	Probably	4 ZÚnknown
VITAL RECORDS, sician: The law requires t	page 2 sh	Completed								24a. Was auto		prior	to completion	ings available of cause of
	certificate rector, pag		C5 Man and referred to madical							1 Yes	2 2 No	death	res 2□ No	)
VII		To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2	ER/Outpatier	nt 3 🗆 l	Othor		eath (Check only of Home SK) Resi		6 □Other /	Specify)	
0 E	After this funeral di		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, E		28b. Time o		28c. Injury a Work?		28d. Describe			poony	
VITE AND IN CHARLES A	tor: A	catle	2 Accident investigate 3 Suicide 6 Could not	ion			М	1 🗆 Ye	s 2 No		_			
DIVISION OF all or Attending Physical Attendents.	Direc in by	Certification:	4 Homicide determine	Zee. Place of t	etc. (Specif	ome, farm, st	reet, facto	ory, office		28f. Location ( City or To			r Rural Route	Number,
UIVISION OT VITA To the Hospitel or Attending Physician: within 24 hours after death.	To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying F	Physician: To the be	st of my kno	wledge, deat	h occurre	d at the time	, date and place	e, and due to the	cause(s	) and manne	r as stated.	
the Hc	the Fu	Medical	(Check only 2   Medical Expone)	aminer: On the basis and manner	of examina	ition and/or in	vestigation	on, in my opir	nion, death occ	curred at the time,	date an	d place, and	due to the car	
T of	To CO	2	29b. Signature and title of certifier	£1-	h.			9c. License r					onth, Day, Ye	
	T.		30. Name and address of person wh	o completed cause o	death (Ites	23a) (Tuna		UJJ	100		Ma	9 13	,2004	
	10		Julie Tinn					Rd	Belv	fir in	D	21014	/	
8		ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa									
	Regist	101	88AV 1 4 91	OOA BAA		W A.	- N 1	D .						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and M  1- Stata Registrar Certificate of Death	- `	giene <sub>leg. No.</sub> 2001	. 15520
			Decedent's Name (First, Middle, Last)	2. Date of Dea	- 100 0 0,	3. Time of Death
	Physici /Medic		Clarence Granger	May	7 2004	9;32AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Ba Himore		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day	1, Year 956 Vil	thplace (State or Foreign ountry)
	land w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e-f sho	ctor	MD NIA Baltimore			1 Nes 2 No
	after death with the Marylan or Items 23s or 28e-f show	Funeral Director	10e. Street and Nymber 89 N. Gilmore S.t. 21217		10g. Citizen of What C	ountry?
36		by Funer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, specify Cuban, Mexican, Puerto  1 Yes, Give 1 Yes, Sive 1 Yes, Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
215-0036	"natural",	ted b	15. Decedent's Education   16a. Decedent's Usual Occupation	ina	16b. Kind of Business	/Industry
21218	be filed within 72 ho tal Hygiene. d other then "natur event, Ir e Medical	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	mig	Constru	iction
Maryland 2	d ta b	To Be C		a (First, Middle,	Maiden Sumame)	
lary	2 shou and M is mar	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run  19c. Mailing Address (Street		r, City or Town, State,	Zip Code)
	1 and Health tem 27 other tr		Virginia Granger - Mother 1638 N. Monkoe St. 20a. Marhod of Disposition 20b. Place of Disposition (Name of	Balto.	20c. Location - City of	Town, State
OE E	Pages nent of ant: If it ury or o		12 Burial 2 Gremation 3 GRemoval from State  12 Burial 2 Gremation 3 GRemoval from State  14 GDonation 9 Other (Specify)  15 Cemetery, crematory or other place)  17 The state of the state	04 1	ansdown	e, mb
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marka any injury or other treumatic ODEs.		21. Signature of Faneral Service Ucensed  22. Name and Address of Facility  Aug. 1. March Fin 27	o Fredhi	ton Pass Bo	ito, mo 21229
			23a. Part Euro he sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or beart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between Onset and Death
X.	Physician /Medical		Immediate Criuse (Final disease of condition resulting in death)  a			
3	Examiner		Sequentially list conditions b. Alcoholism			
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury)  Due to (or as a consequence of):			
50,	ficate be executed physician and s the burial-transit		that initiated events c. resulting in death) Last Due to (or as a consequence of):			
68760	ficate by physical streets the	edicai	d			
). Box	The faw requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	olivery Day Year
P.0	res that the de signed by the a be detached to	y Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a. Did to	bacco use contribute t	o the cause of death?
rds	w requires been sign should be	ted by		1 🗆 Y	es 2. 1 No 3 □ P	robably 4 Unknown
Records,		Completed	<u></u>	24a. Was autop	sy prior to death?	utopsy findings available completion of cause of
Viital	rysicien: Th nis certificete director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital: Other: Other: Other:			
	ding Phys After this funeral di	tion; To	27. Manner of Death 1		ence 6 Other (Spe ow injury occurred	ecify)
Division of	를 들는 를	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospitel or Al within 24 hours efter of To the Funerel Direc completely filled in by	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the ored at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier  29c. License number  DC05295	0	29d. Date signed (Mon	th, Day, Year)
	2		30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)  A MONT SMITH SMI	7 0 0 0	7.10	-
	Sta	ite	31 Date filed (Month Day Year) 32 Registrar's Signeture	) X CC		
	Regist		MAY 1 1 2004 Sever & sports			

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Mary Ann Garvey R.S.M. 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death The Villa Pinehurst Baltimore 8. Date of Birth (Month, Day, Year) if Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex Days Hours 1 □ M 2 1 F Months 220-54-8314 08/15/1930 MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD <u>Balrimore</u> Pinehurst 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 6806 Bellona Ave. 21212 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Sister Religious 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James F. Garvey, Sr. Gertrude Imelda Holbein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Baltimore, MD 21239 20c. Location - City or Town, State Sisters of Mercy 1300 E. Northern Parkway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 05/15/04 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 21. Signature of Funeral Service Licensee MOOBEG 736 Edmondson Ave. Baltimore, MD 21228 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, inheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athoroschootic andiovasular dispose Due to (or as a consequence of): haranterin

/Medical Examiner ettending physician end for use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, veral Director: A To the Mespital within 24 hours a To the Funeral C completely filled

Physician/Medical Examiner

Be Completed by

Medical Certification: To

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show uniner must be notified at

marked other

permit. Pages 1 end 2 should be to Department of Health and Mentel I Important: If Item 27 is marked of

**Physician** 

Completed by Funeral Director

ann Landey, Kom

Baltimore, Maryland 21215-0020

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Sequentially tist conditions, if eny, teading to immediate	Due to (	or es e consequence d	•									
cause. Enter Underlying Ceuse (Disease or injury	c. Diobe	tes mell	itus		unKnown							
that initiated events resulting in death) Last	Due to (	Due to (or es a consequence of):										
C	d											
Part II. Other significant conditions of	contributing to death but not re-	sulting in the underlyin	g ceuse given in Part I.	23b. Did tobacco use c	ontribute to the cause of death?							
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
				1 LI Yes 2 2 No	1 ☐ Yes 2 ☐ No							
25. Was case referred to medical examiner?	26. Place of Death (Check only one)											
1 ☐ Yes 2 ☐ No	Hospitat: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5⊿Residence 6 □O	ther (Specify)							
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigetio	28e. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	urred								
3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, fact fy)	28f. Location (Street and Nun City or Town, State)	nber or Rurel Route Number,								
				e, and due to the cause(s) and nurred et the time, date and place								
29b. Signature end title of certifier			29c. License number	29d. Date sign	ned (Month, Dey, Yeer)							

DHMH 16 Rev 6/95

antaw

32. Registrar's Signature

30. Name end eddress of person who completed cause of death (ttem 23e) (Type, Print)

Pm 206

31. Dete filed (Month, Dey, Year)

Director    215-48-9815   XX M 22F   57 Yrs   Jan. 18,1947 Mar	th  e  thplace (State or Foreign ountry)  ryland  10d. Inside City Limit  1   Yes XXN  ountry?  erican Indian, tte, etc.  White  White  Whole  County  Zip Code)  111  r Town, State  Maryland  A.  ryland 2122
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5. Social Security Number 215-48-9815  215-4	thplace (State or Foreign cyland  10d. Inside City Limit 1 Yes XXN  ountry?  erican Indian, te, etc.  White Windustry  E County  Zip Code)  111  Town, State  Maryland  A.  ryland 2122
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Walter Louis Goertz    Separation   Projection   Marcia	111 rTown, State , Maryland .A. ryland 2122
Watter routs goertz  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or	111 rTown, State , Maryland .A. ryland 2122
Jacqueline Goertz (Wife)  20a. Method of Disposition  1	111 rTown, State , Maryland .A. ryland 2122
20a. Method of Disposition    Sequentially list conditions, if any, leading to immediate	Town, State  , Maryland  .A.  ryland 2122
Bayview Crematory  May 13,2004 Baltimore,  1 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Bruzdzinski Funeral Home, P.  1 407 Old Fastern Avenue, Essex, Mar  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,    Immediate Cause (Final disease of condition resulting in leath)   Due to (or as a consequence of):    Due to (or as a consequence of):	.A. ryland 2122
Prysician  Medical  Examiner  Sequentially list conditions, if any, leading to immediate by the sequence of th	.A. ryland 2122
Prysician  Medical  Examiner  Sequentially list conditions, if any, leading to immediate by the sequence of th	.A. cyland 2122
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease of condition resulting in feath)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
Prysician //Medical Examiner    Immediate Cause (Final disease of condition resulting in Jeath)   Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Medical Examiner  Sequentially list conditions, if any, leading to immediate that the following in the sequence of the sequenc	Unknown
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Tany, leading to immediate cause. Lifter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Co. Due to (or as a consequence of):	
that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
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6876 gg physicia as the bu	
W IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (specify)	elivery Day Year
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)    1   Yes 2   No 9   Unknown  23d. Date of de Month	ouy rou.
9 Unknown  9 Unknown  9 Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to	to the cause of death?
Solution of the past 12 months?  1   Yes 2   No 9   Unknown  1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)    1   Yes 2   No 9   Unknown  23d. Date of de Month  4   Pregnant at time of death 5   Other (specify)    9   Unknown  23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)    23e. Did tobacco use contribute to 1   Yes 2   No 3   Petal death 5   Other (specify)	robably 4 Unknow
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The state of the	autopsy findings available completion of cause o
The second secon	3 2 110
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spe	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	
So the state of th	
The standard of the standard o	ecify)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and the time, date and place, and due to the cause(s) and manner and the time, date and place, and due to the cause(s) and manner and due to the cause(s)	ecify) Rural Route Number, as stated.
29d. Date signed (Mon	ecify) Rural Route Number, as stated.
10/0748	ecify)  Rural Route Number,  as stated. se to the cause(s)  nth, Day, Year)
Acguerawalt MD D60248 May 12,	ecify)  Rural Route Number,  as stated. se to the cause(s)  nth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ecify)  Rural Route Number,  as stated. se to the cause(s)  nth, Day, Year)
	ecify)  Rural Route Number,  as stated. se to the cause(s)  nth, Day, Year)

DHMH 17 Rev 1/2001

ÓRIGINAL

		-	For State Registrar	State of Maryland /	Department of He Certificate of D		ntal Hygiene Reg. No	2004 15	541
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last)	H	awkins	n	Date of Death Month Da Agy 9	y 2604 11/5	Death M
	Examin Funeral	er	4e. Fecility Name (If not institution, give si  NONCY PROBLE  5. Social Security Number 6. Sex  1. Security Number 1. Security	cal Courte	4b. City, Town, or L  birthday) If Under 1 Year  Months Days	If Under 24 Hrs. 8.	Date of Birth	9. Birthplace (State of Country)  9. Many Institute of Country)	
	Director show		Usuel Residence of Decedent  10a. State  10b. County	10c. City, To	own or Location		programme	10d. Inside C	
	with the had or 28e-	Direct	100. Street and Number		10f. Zip Code	13		tizen of What Country?	
36	72 hours after death with the Maryland natural; or items 23e or 28e-f show dical Exerciper coust be notified at	by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	panic Origin? (Specify, Mexican, Puerto Ric Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
21215-0036	_	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		6a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired) Parker	ion iring most of working		and Motors	
	2 should be filed withir and Mental Hygiene. is marked other than aumetic event, the M	To Be Co	17. Father's Name (First, Middle, Last)  RAYMEND HAW	kins		18. Mother's Name (F		n Sumame)	
Maryland	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Ty)		9b. Mailing Address (Street as	406 BALL	hours the	d 3/2/3	
Baltimore,	Pages 1 and 2 tent of Health nt: If item 27 ry or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	20b. Place	of Disposition (Name of etery, crematory or other place	5/12	1/ey BR	ocation - City or Town, State	lows
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	is a second	22. Name and Address 5 2 YO RETU	of Facility CHA	NOAZ	Bothers made	2/2//
ON ALCOHOLISM	Pnysician /Medical Examiner		esa Part 1. Enter the disease, or complishoot, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. [e cause on ach line.]		, such as cardiac or r	espiratory arrest,	Approximal Interval Be	etween
8760,	sate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, the least sequentially leads to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent					
P.O. Box 68	death certific ne attending p ed for use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic pregnancy			23d. Date of delivery Month Day	Year
	quires that the n signed by th uld be detach	d by Ph	Part II. Other significant conditions con	10 - //	ng in the underlying cause give	n in Part I.	23e. Did tobacco	ouse contribute to the cause of No 3 Probably 4	f death? ]Unknown
Division of Vital Records,	The law require ate has been signage 2 should b	Complete		,			24a. Was an autopsy performed?	24b. Were autopsy finding prior to completion of death? 1 □ Yes 2 □ No	s available cause of
f Vita	Physician; The this certificate had al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		VOutpatient 3 DOA	4   Nursing Home	5 Residence	6 ☐Other (Specify)	
ion o	0 0 0		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		? /es 2 □ No	d. Describe how inj		
Divis	To the Hospitel or Attending I within 24 hours after death. To the Funerel Diractor: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)			City or Town, Sta		mber,
	Fo the Hospitel or within 24 hours afte Fo the Funerel Dir. completely filled in 1	Medical	29a. Certifying Phy (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the tim n and/or investigation, in my op	ie, date and place, an pinion, death occurred	at the time, date a	nd place, and due to the cause	
	Vithir comp	W	29b. Signature and title of certifier	iken m	29c. License	- 1815-1	29d. 0	Nate signed (Month, Dey, Year)	204-
-	"		30. Name and address of person who c	mpleted cause of death (Item 2)	3a) (Type, Print)	301 5	Balto	2 Mare	2
	St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	" & Sport	2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death **Physician** arie /Medical ity, Town, or Location of Death 4c. County of Death **Examiner**  Birthplace (State or Foreign Country) (In yrs. last birthday **Funeral** 1□ M 2**X**F Director death with the Maryland 10c. City, Town or Location 10a. State 10b. County nside City Limits if item 27 is marked other than "naturel", or items 23s or 28e-f show or other traumatic event, the Modical Exertities at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code SA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) if item 27 i altimore, 20a, Method of Disposition 1 Burial 2 Cremation \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensel Vacha Draw 0 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician VICa disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Inter Inder ing Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed buriai-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? jo 5 Other (specify) 1 ☐ Yes 2 2 9 ☐ Unknown detached 9□ Unknown s been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No Completed 1 Yes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2□ No 1 🗌 Yes 2 No 1 Yes Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 4 
Nursing Home 5 ☐ Residence 6 △ ther (Specify) hospice 28a. Date of Injury (Month, Day Year) 27. Manner of Seath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending after death. Director: Aft 1 🗌 Yes 2 No 2 Accident investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire Hospital Till Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) To the 29b. Signature and lite of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28303 w Name and address of person who completed cause of death (Item 23a) (Type, Print) harles 31. Date filed (Month, Day, Year) 32. Registrar's Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9 Year 11: 45A M May 2004 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bultimore Hopkins Bayview Medical Genter N/A Johns If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01/02/1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number NEW YORK 1 ☐ M 2 ☑ F 80 116-14-2402 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 □ No HOWARD COLUMBIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5764 STEVENS FOREST RD #314 21045 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 □ Yes 2 No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. WHITE ☐Yes 2X No Yes, Give 1 Never Married 2 Married Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER WEST CHESTER, COUNTY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSE TURETZ **HERSHKOWITZ** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5764 STEVENS FOREST RD COLUMBIA, MD 21045 GEORGE HOROWITZ / HUSBAND 20a. Method of Disposition

1 DABurial 2 Cremation 3 Removal from State

4 Dogation B Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 05/13/2004 VALHALLA, NEW YORK SHARON GARDENS of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 complica of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only only of use on each line. Approximate Interval Between Onset and Death Enter the disease. shock, or heart failure. List only Immediate Cause (Finaf hemorrhage 2 days Intra cerebral disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. ff yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

SAM ပ

**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Itam 27 is marked other than "natural", or Itama 23a or 28a-1 show other traumatic event, Ita Medical Examinar must be notified at

al Hygiene.

is marked of

Pages 1 and 2 sl ment of Health and ent: if Itam 27 is r

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Examiner sician and burial-transit

physician s the burial 186 ō the ģ signed b certificate has birector, page 2 s this After death.

Diractor: filled in by after

The law requires that the death certificate be executed Hospital or Attanding

within 24 hours a To the Funeral I State Registrar

Physician/Medical IF FEMALE: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be P 27. Manner of Death Certification: 1 X Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifier

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

 Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending investigation

6 Could not be

determined

29c. License number RES-000

Bultimore

29d. Date signed (Month, Day, Year) 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue Dr John Eckman, MD 31. Date filed (Month, Day, Year)

4 2004

32. Registrar's Signature

		•	1 = For State Registrer	State of Maryland	d / Depa <i>Cer</i> i	rtment of F	lealth and <b>I</b> Death		giene 2 Reg. No.	2004	15544
1			1. Decedent's Name (First, Middle, Las	it)			<del></del>	2. Date of De		Year	3. Time of Death
	Physici: /Medic		Alice	E,		H :11:	ger	may	10	2004	11:53 PM
	Examin	er	4a. Facility Name (If not institution, give		/-	4b. City, Town, o	r Location of Death			ounty of Death	
			Johns Hopkins Payvi 5. Social Security Number 6. So	IEW Medical Ce	nter	If Under 1 Year	Z/+/MON	8. Date of Birt	NIA		place (State or Foreign
	Funeral Director			M 202F	Yrs.	Months Days	Hours Min.	JAN 20	y, Year)	Сои	y/and
	ס		Usual Residence of Decedent				<del></del>	7	1750		
	arylar ehow	_	10a. State 10b. County		, Town or Loc						10d. Inside City Limits 1  es 2  No
	Ba-f	ecto	Mb N/A  10e. Street and Number	Dal	Himor				10= Cities	4 1 M/1 - 1 C	
	with is or	Ö	631 N. Wooding	Han Rd.		10f. Zip Code			USA	n of What Cou	nuy :
	death ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. W	as Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		. Race - Ameri	
စ္	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	)	Yes, specify Cuba		o Rican, etc.)		Black, White,	2 8
21215-0036	within 72 hours atter death with the Maryland one. ttan "natural", or Items 23a or 28a-f ehow the Medical Exeminat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							lacK
15-	"natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give k	ent's Usual Occup rind of work done O NOT use retired	during most of wor	king	16b. Kind	of Business/In	dustry
72	withii iene. than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Bank	« Telle	•		Ban	K	
D D	filed Il Hygi other		17. Father's Name (First, Middle, Last)		3-01-17	7-7-	18. Mother's Nan	ne (First, Middle,	Maiden St	umame)	
/lar	2 should be filed withir and Mental Hygiene. ia marked other than aumatic event, the Ma	To Be	Charles White St	₹.			Vernice	Colem	141		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or Items 23a or 28a-1 show appring to other traumatic event, the Medical Examination at an apprece.		19a. Informant's Name/Relationship (7	1	19b. Mailing		and Number or Ru			Town, State, Zij	Code)
	1 and Health em 27		Harold Hollinger  20a. Method of Disposition	- husband	03) IV	ition (Name of	igton Ad	Dalto		ation - City or To	Ourn State
altimore,	Pages nent of H		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, crem	atory or other plac	· 1 -				
亞	permit. Pag Department Important: any injury c		' 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		odlaw	Name and Addre	PERY 5-15	-04	wood	lawn,	mo
Ba	permit. Departr Imports any inje		Vanu 1 4	my /	Cor	V P March	/	Fredhilt	no Pas	s Balto.	mo 2/229
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only	plications that caused the death	. Do not ente	r the mode of dyir					Approximate Interval Between
D	Pnysician		Immediate Cause (Final disease or condition		us Herri	dinal .	bland			d)	Onset and Death
	/Medical		resulting in death)	a to (or as a consequ	ence of):	TINAL	oreea			-	sne day
W	Examiner	L.	Sequentially list conditions, if any, leading to immediate	b	ones of):						
) -	ted	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or).					3	
	axecu al-trai	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	ence of):						
8760,	death certificate be executed attending physician and of for use as the burial-transit			đ							
9	ntificat ng phy as th	Physician/Medical	IS SELVILS								
Вох	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	,		23	d. Date of delive Month	ery Day Year
Э. П		/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5□	Other (specify)				WORLD	Day
P.0.	The law requires that the de site has been signed by the a page 2 should be detached i	Ph)	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the un-	derlving cause giv	en in Part I.	23e. Did to	obacco use	contribute to t	he cause of death?
of Vital Records,	signe d be	d by				,g g		1 🗆 ١	/es 2 □	No 3∏Prot	pably 4 Munknown
COL	w require been si should?	Completed			-			24a. Was	an	24b. Were auto	ppsy findings available
Re	The lav	ошо						autop	sy		impletion of cause of
ital	ilcian: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Dea	th (Check only o		10163	2010
	Physician: rthis certificatal director,	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 XInpatient 2 □ E	ER/Outpatient	3□ DOA Oth	er: 4□ Nursing H	ome 5 Resid	dence 6 [	□Other (Specil	(y)
ס	Attending Physician: 'r death. sctor: After this certifica		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h			
Sio	Attending r death. sctor: After y the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ma farm atra		Yes 2 □No	29f Location /6	Stroot and I	Number or Pur	al Route Number,
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	)	et, ractory, onice		City or Tow		VUITION OF THE	ar noble Namber,
_	spita nours neral / fillec		29a. Certifier 1 Certifying Ph	ysicien: To the best of my know	vledge, death	occurred at the tin	ne, date and place	, and due to the o	cause(s) ar	nd manner as s	tated.
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	(Check only 2 Medical Exen	niner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my o	pinion, death occu	rred at the time,	date and pl	lace, and due to	o the cause(s)
ı	To t To t	Σ	29b. Signature and title of certifier	m D. Dh.D		29c. Licens				signed (Month,	
,			Ynethe Brown	, ,		KES.	-000		May	11,2004	
	6		30. Name and address of person who	completed cause of death (Item	23a) (Type, F	Print)	Wastle	Radina	, M :	n .1125	7
	Sta	to	31. Date filed (Month, Dav. Year)	32. Registrar's Signati	uge	/	0001767	AA (JIN) ON	C / /*[(	2128	+
	Sta Registr	ar	31. Date filed (Month, Day, Year)  MAY 1 4 2004	pengur /	9 4	souls					

	• •	/ Department of Health and M  Certificate of Death	
Physician /Medical Examiner	Decedent's Name (First, Middle, Last)     BERNARD M.  4a. Facility Name (If not institution, give street and number)	IMBER  4b. City, Town, or Location of Death	2. Date of Death Month Day Year Ac. County of Death 4:15 P M
Funeral Director	HOSPICE OF BALTIMORE GILCHRIST CI  5. Social Security Number 212-32-5560  Usual Residence of Decedent	ENTER TOWSON st birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth, Nonth, Day, Year) APR. 14, 1934  BALTIMORE  9. Birthplace (State or Foreign Country) MD
with the Maryland t or 28e-f ahow the notified at Director	10a. State 10b. County 10c. City,	Town or Location  BALTIMORE  10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2 ☑ No  10g. Citizen of What Country?
er death v Itams 23e Det must	22 I HUMAS CRADUCK COURT  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	21208  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto for the Specify:	U.S.A.  cify Yes or No- lican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filled within 72 hours alt Department of Health and Mental Hygiene. mportant: If itam 27 is marked other than "netural", or my injury or other traumatic avent. Its Medical Exami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+	DEPT. OF DEFENSE	
aryland should be fill should be fill and Mental Hy a marked oth umatic aven umatic aven To Be	17. Father's Name (First, Middle, Last)	IMBER PAULIN	(First, Middle, Maiden Surname)  BINNICK
Ma d 2 3 d 1 ar T is	19a. Informant's Name/Relationship (Type, Print) PEARL IMBER / WIFE		T - BALTIMORE, MD 21208
Baltimore, permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other one.	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, crematory or other place)	20c. Location - City or Town, State  / 2004 WOODLAWN, MD
Baltimo permit. Pag permit. Pag Department Important: I any injury o once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL	LEVINSON & BROS., INC. OAD - PIKESVILLE, MD 21208
B760, Aredical Examiner  Ilcal Examiner	d	ance of):	respiratory arrest, Approximate Interval Between Onset and Death
ords, P.O. Box 68760, requires that the death certificate be executed requires that the death certificate be executed even signed by the attending physician and hould be detached for use as the burial-transleted by Physician/Medical Examile	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
ds, P.  dires that the signed by dip detact		ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No ③ Probably 4 ☐ Unknown
tal Records, ital Records, in The law requires the trifficate has been signed ctor, page 2 should be 38 Completed by			24a. Was an autopsy prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Division of Wital Rec  To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 si	1 Yes 2 No Hospital: 1 Inpatient 2 E	28b. Time of Injury At Work?  M 1 Yes 2 No	(Check only one)  ne 5 ☐ Residence
bt.  In the Hospital thin 24 hours of the Funarel mpletely filled	29a. Certifier (Check only one) Physician: To the best of my know one) Medical Examiner: On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occurre	ed at the time, date and place, and due to the cause(s)
or is is a con	30. Name and address of person who completed cause of death (Item 2	29c. License number D 57303  23a) (Type, Print)	29d. Date signed (Month, Day, Year)  MAY 11 ZOOY
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 1 4 2004	·	Huore MO 2007

DHMH 17 Rev 1/2001

**ORIGINAL** 

Gerard Johns 04-03180 MAN

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2 Date of Death . <sup>Day</sup> 2004 IDHNS TERARD **Physician** May 11, 0614 A<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

Yrs. **Funeral** 1 M 2□F Days 212.46.6550 Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event. The Medical Examinar must be notified at 1 Yes 2 No Director JAIT, MORE MTD10e. Street and Numbe 10g. Citizen of What Country? ö or Itams 23e death v Funeral 14. Race - American Indian Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. med Forces? Yes 2 ☐ No 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Itar 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: ð 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GENERAL MOTORS College (1-4or 5+) Elementary/Secondary (0-12) TRAINER 18. Mother's Name (First, Middle, Maiden Sumame)
JEANETTE, GRIFFIN 17. Father's Name (First, Middle, Last Be 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) WINDEMERE BALTO, MO 21218 WIFE KOAO Pages 1 and 2 ment of Health a 1307 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 5.17.04 TOWSON, MARYLAND injury or DULANEW VALLEY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAVAHN C. GLEENE FUNELINE HOME 21. Signature of Funeral Service Licensee YORK ROAD BALTIMORE, WO Vary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCIERORC CARDIOVASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, localing land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consiguence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 XYes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending after death. investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chre to O.C.M.E. May 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUB 10 MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (AY

DHMH 17 Rev 1/2001

62. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200 AM **Physician** ONES HARLES /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner cienel land If Under 1 Year If Under 24 Hrs. B. Date of Birth All (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 220-56-798 1 M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1. Yes 2 No Director MARYLAND og. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a STREE ANN Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours att. Department of Health and Mental Hyglens. In Tatural', or Important: If Hem 27 is marked other then "natural', or early lojury or other treatment ovent. The Medical Exemple only prother treatments event. The Medical Exemple only prother treatments ovent. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) THGRADE USTODIAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland Be ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 'AROLYN SHOEMAKER (FRIEND) 1116 SARAH ANNST. 20b. Place of Disposition (Name of cemetery, crematory or other place) Itimore. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERIA 05-18 BALTIMORE MARKAND 1 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS 22. Name and Address of Incility

JOSEPH H. BROW FUNERAL HOME 21. Signature of Funeral Service Licensee FULTON AVE. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) **Physician** a tumondy <u>ansc</u> /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence burial-transit Exami +mi and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Xes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 Ves 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Medical Certification: To 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu To the Hospital

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, 1 4 2004

29b. Signature and title of certifier

29a. Certifier

30 Name and address of person who completed cause of death (frem 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001

		-	For State Registrar AMEND TIEM &1	5 PER FH C831 5/1				Reg	2004	15549		
	Physicia	an i	1. Decedent's Name (First, Middle, Last	5.	Ju	stice		2. Date of Death Month	9 2004	3. Time of Death 3:00 AM		
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	h	4c. County of Deal	h		
	Funeral Director		5. Social Security Number 6. S 319 - 28 - 1320		last birthday) Yrs.	If Under 1 Year Months Days			9. Birt	hplace (State or Foreign huntry)		
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limits		
	e Mary ta-f sh tiffed	Director	MD NIA	Bal	itimore					1  Yes 2 No		
	ath with th	rai Dire	104 N. Edgewood			101. Zip Code 21239		U	g. Citizen of What Co			
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it e Marical Executar must be rediffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		as Decedent of Yes, specify Cut □ Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit			
15-0	in 72 ho n "natur Aszlical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give k	ent's Usual Occu and of work done O NOT use retire	during most of wo	rking 10	6b. Kind of Business	Industry		
212	led within lygiene. her than "	Com		4yrs 475	Nursi	೬	1	F	lospital			
land	uld be fil fental H rked otl tic even	To Be	17. Father's Name (First, Middle, Last)	Stokes			Maude Maude	me (First, Middle, Ma Johnson	aiden Sumame)			
Maryland 21215-0036	1 and 2 should be Health and Menta em 27 Is marked ther traumatic ev		James Justice -	Type, Print) NUSDANO	19b. Mailing	4	wood St.	Balto, m	City or Town, State, 2	Zip Code)		
Baltimore,	Pages 1 and the properties of		20a. Method of Disposition  1	20b.	Place of Dispos cemetery, crem. bulus A	ition (Name of atory or other pla		Date 20	butus n			
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of uneral Service Licer			Name and Addr	ess of Facility	-	_ 05	0., mp 2/229		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not ente					Approximate Interval Between Onset and Death		
	Pnysician /Medical		Immediate Cause (Final disease condition resulting in death)	a		nae Ca	cinoma			2 roouths		
	Examiner		Sequentially list conditions	Due to (or as a consect.	quence or):							
I	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):							
68760,5	rtificate be executed ng physician and sas the brial-transit		that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
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۵.	that ed b deta	by	Part II. Other significent conditions of	ontributing to death but not re	sulting in the un	derlying cause g	ven in Part I.		cco use contribute to	the cause of death?		
Vital Records,	: The law requires cate has been sign , page 2 should be	Completed						24a. Was an autopsy performe	prior to	ntopsy findings available completion of cause of		
/ital	Physician: this certifica	Be C	25. Was case referred to medical examiner?	Manitali				ath (Check only one)				
of		lon: To	1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju		10me 5 Residen 28d. Describe how	ce 6 COther (Specialist of the control of the contr	city) Hospace		
Division	i a : e	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		nome, farm, stre			28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,		
-	Hospital 4 hours 7 hours 7 hours 8 hours 14 hours 16 hours	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or inve	occurred at the testigation, in my	ime, date and place opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)		
	To the within 2 To the complete	Med	29b. Signature and title of certifier	une manner stateu.		29c. Licen	se number	290	d. Date signed (Monti	h, Day, Year)		
)			> Swilliam	Benedier on		700	8583		5/11/04			
	5		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, F	Print)	1. th' ma	40 2120				
_			O' WILLAM IJEN	13 DICT, 6565 N	· Whatles	101	TULINOTE,	MU 21200	7			

		1	For State Registramend TTEM #7 PER	State of Maryland R FH C831 5/14/04					iene	1. 15550
			Decedent's Name (First, Middle, Last)	4				2. Date of Deat	h	3. Time of Death
	Physicia /Medic		LLOYD NELSON	JACKSON				05-12	- 2004 Year	8:05 AM
	Examin		4a. Facility Name (If not institution, give s 4220 FRF,DRIC	treet and number)  AVENUE	4b.	City, Town, or	Location of Death	1	4c. County of Dea	ith
	Funeral Director		401.04.160K	7. Age (In yrs. la		Inder 1 Year onths Days	if Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day,	9. Bi	thplece (State or Foreign ountry)
	death with the Maryland ms 23a or 28a-f show rmust be notified at	-	Usual Residence of Decedent  10a. State  10b. County  A		Town or Locatio					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Funeral Director	10e. Street and Number	DAE		of. Zip Code		1	0g. Citizen of What C	ountry?
	3a or	<u>a</u>	4220 FREDRICK	AVENIUE		2122	29		USA	
	ams 2	iner		12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was	Decedent of Hi	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
920	72 hours after netural, or Ita	þ	1 ☐ Never Married 2 <b>¼</b> Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>(1)</b> No If Yes, Give Year or Dates:	101	res 2 No	Specify:		Specify: B	LACK
2-0	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's (Give kind	of work done of	during most of wor	king	16b. Kind of Business	s/Industry
21215-0036	d within giene. or then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	TRUC	IOT use retired	RIVER		TRANSPO.	RTATION
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the Marylan item 27 is marked other than "natural", or Itams 23s or 28s-1 show other traumatic event, the Medical Exam par must be notified at	To Be C	17. Father's Name (First, Middle, Last) BUDDY JACKSON	7			18. Mother's Nar DELIA	ne <i>(First, Middle, M</i> HARRI	Maiden Sumame) S	
ary	2 should and Men Is marka aumatic	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailing Ad	dress (Street a	and Number or Ru	ral Route Number	City or Town, State,	Zip Code)
III.	1 and 2 Health em 27 I		1ERESA JACKS	ON 20h Pi	4220 lace of Disposition	FKED!	ZICK A	VE., BA	20c. Location - City o	21229 Town State
altimore	Pages nent of the	3	20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Ri  4 □ Donation 5 □ Other (Specify)	emoval from State	BUTUS	y or other plac	05-1		BALTO, M	Q
Baltiı	permit. Page Department o Importent: If any injury or once.		21. Signatore of Funeral Service License	No. of the last of	A STATE OF THE PARTY OF THE PAR	me and Address	ss of Facility	FUNERA	H SERVICE ALTO. MD	24229
d			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death	n. Do not enter the	e mode of dyin				Approximate Interval Between
	- Pnysician	ė i	Immediate Cause (Final disease or condition resulting in death)	netastal	e neu	roendo	onine c	carcinon	na	Onset and Death
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)	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	-				
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9	ntifica ing ph a as th	Med	IF FEMALE:							
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ds, P.	uires that the d n signed by the ild be detached	by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the under	lying cause giv	en in Part I.			to the cause of death? Probably 4 20nknown
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ital		Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only on		
of V	Physician: this certific ral director,	To I	1 ☐ Yes 2 ☐ No	1		DOA Oth	4   Nursing F		ence 6 Other (Sp	ecify)
ou	ding h. After fune	tlon:	27. Manner_of Death  1 ②Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor M 1 □	yat k? Yes 2 □ No	280. Describe no	ow injury occurred	
Division	I or Attending after death. Director: After I in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
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	To the within 2 To the comple	Med	29b. Signature and title of certifier	and marrier states.		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
	- > - 0		- Can mal	li-no		0227	782	1	nay 12,20	04
	8		30. Name and address of person who co	empleted cause of death (Item	Jucth H	onour	Skreet	Bulmare	Merylan	12/225
5	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	g spi	nks				

			i lease	State of Marylan	d / Departmer	nt of Health and	Mental Hygie	ene o o o o	
		1	For State Registrar	,,		te of Death		No. 2004	15551
		20	Decedent's Name (First, Middle, La				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ANNABELL	JONES			05	12 2004	
	Examin	_	4a. Facility Name (If not institution, giv	1 1/2	4b. City	Town, or Location of Dea	ath	4c. County of Death	
				ex 7. Age (In yrs.	lack highday) If Under	r 1 Year   If Under 24 Hr	S. 8 Date of Birth	NA Birth	place (State or Foreign
	Funeral Director			M 2DF	87 Yrs. Months			1916 Cou	ntry) IIA.
T			Usual Residence of Decedent				178817 0-07		
o e local	whow I a	_	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits 1 ☐ es 2 ☐ No
M	Sa-f	Director	MD NA		HILIMOY	p Code	100	. Citizen of What Cou	
boelwell of the Manufact	a or 2	DI	301 Mc M	11 / Shit	£ 502	71717	1	164	intry :
deco	ma 23	Funeral	301 Mc M	12. Was Decedent Ever in U.	S. 13. Was Dece	ident of Hispanic Origin? ( acity Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ameri	
č	or Ite	교	1 Never Married 2 Married	Armed Forces?  1  Yes 2 7 6  If Yes, Give	π Yes, spe		ano Rican, etc.)	Black, White	, etc.
503	E	d by	3  Widowed 4 □ Divorced	Year or Dates:				pla	CK
ָה הַ	nett	lete	15. Decedent's E (Specify only highest gr.	ducation ade completed)	16a. Decedent's Usu (Give kind of w	ial Occupation ork done during most of w ise retired)	orking 16	b. Kind of Business/Ir	ndustry
d 21215-0036	than	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	Domes			Homes	•
Maryland 21215-0036		BeC	17. Father's Name (First, Middle, Last		3077.		ame (First, Middle, Ma	iden Sumame)	
arylar	marked	To E	Walter Ho	dams		Beula	th Ada	m5	
اعا			19a. Informant's Name/Relationship	Type, Print)	19b. Mailing Addres	s (Street and Number or I	1	•	
	f Health item 27 other to		DerNice John 20a. Method of Disposition	SON - triend	Place of Disposition (Na	Ubrook HUE		MD ZIZ c. Location - City or T	
altimore,	nant of h		1 Burial 2 Cremation 3	Removal from State	emetery, crematory or	other place)			
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the deat	h. Do not enler the mo	de of dying, such as cardi	ac or respiratory arres	1,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a conseq	uence of):	J C. J.			
Ŀ	Examiner		Sequentially list conditions,	b					
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89	that the death certilicate ed by the attending phys detached for use as the								
Вох	n cer endin r use	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta		pregnancy		23d. Date of delive	very Day Year
П	e dea the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of d 9☐ Unknown	leath 5 Other (s	specify)		World	Day Toal
P.O.	nat in ad by detack	Phy	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	signe d be	d by				•	1 ☐ Yes	2 No 3 Pro	bably 4 dunknown
COL	w required	ete					24a. Was an	24b. Were aut	opsy findings available
Re	ne iar e has age 2	Completed					autopsy performe	death?	ompletion of cause of
<u>ta</u>	an: I	Be C	25. Was case referred to medical			26. Place of D	eath (Check only one)	3140 10 103	20.00
>	nysici nis ce	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 □Other (Spec	ify)
0 0	ng PI After th Ineral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fniury	28c. Injury at Work?	28d. Describe how	injury occurred	
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Division of Vital Records,	or Al atter ( Direc in by	Certification:	4 Homicide determined	building, etc. (Special	fy)	ry, office	City or Town,		ar riodie ruinber,
_	To the Hospital or Attending Physicien: The law fequires tha within 24 hours atter deal of the Funeral Director: After this certificate has been signed completely tilled in by the funeral director, page 2 should be determined.			hysician: To the best of my kno					
	ne Ho n 24 h ne Fu	edical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or investigation	n, in my opinion, death oc	curred at the time, date	e and place, and due	to the cause(s)
	To the Comp	Ž	29b. Signature and title of certifier	1	25	9c. License number		I. Date signed (Month	, Day, Year)
7	^		186	toth.		8420	3 10	5/12/04	
	1		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	Land	Denein	1 1/2	i.tal
	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	adiana	CUICIO	1 170	VIIII.
	Regist		MAY 1 4 200		South )				

		-	_ 31616	of Maryland / Depa	artment of Health and	l Mental Hygie		15552
ı	Physicia		1. Decedent's Name (First, Middle, Last)	Johnson		2. Date of Death Month		. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of De	1	4c. County of Death	7.50
	LXaiiiii		Bon SErour Hos	15410	Baltimores		Nk.	
	Funeral Director		5. Social Security Number 6. Sex 15 M 2	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	in. (Month, Day, Yi	ear) 9. Birthplace Country) 19 26 M.D	(State or Foreign
	land ow	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d.	Inside City Limits
	the Marylan 28a-f ahow notified at	ctor	M.D N/a	BAItI	nure			1 Pres 2 □ No
	or 28	Dire	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?	
	eath w	Funeral Director	2840 W. MWbERRY 11. Marital Status 12. Was 1	OFREEF Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American I	ndian,
9	o within 72 hours after death with the Maryland jiene. Jiene. It than "natural", or Itams 23a or 28a-f ahow Itse Medical Everith with at Le notified at		Ame	Forces?	If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 No Specify:	erto Rican, etc.)	Black, White, etc.	
5-0036	n 72 hours "natural",	d by	3 Widowed 4 Divorced Year	or Dates:		10	Specify: BIACK	
215-	na na	Completed	15. Decedent's Education (Specify only highest grade completed)	ed) (Give	edent's Usual Occupation a kind of work done during most of v DO NOT use retired)	vorking	<ul> <li>b. Kind of Business/Indust</li> </ul>	ry
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	should be filed within and Mental Hygiene. marked othar than matic evant, the M	Be	17. Father's Name (First, Middle, Last)			lame (First, Middle, Ma	iden Sumame)	
Maryland	s 1 and 2 should be f Health and Mental fram 27 la marked c othar traumatic eve	2	William Jehnson  19a. Informant's Name/Relationship (Type, Print)	19b. Mail	MARA		City or Town, State, Zip Co	de)
	nd 2 :salth ar		PASTOR Clifford Johns	-	W. Mulberry I	1 - 1	MD 21223	
altimore,	00	H	20a. Method of Disposition  1 Surial 2 □ Cremation 3 □ Removal f	20b. Place of Disp	matory or other place)		c. Location - City or Town,	State
tim	Pag tment tant: I		'4 ☐ Donation 5 ☐ Other (Specify)	Dauchal	YARK 5/ 2. Name and Address of Facility	10/04 1	32 Hmix MI	)
Bal	permit. Pag Department Important: I any injury o		21. Sature o Funeral Service Licensee  Patricia Bu	6			fimers, MD a	
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	at caused the death. Do not er on each line.	iter the mode of dying, such as card	liac or respiratory arrest	t, Ap Int On	proximate erval Between iset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	to (or as a consequence of):	DXEEQ.			- 10-
	Examiner			to (or as a consequence or).				
	p ii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):				
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8760,	ate be ex hysician the buria	calE	d					
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Вох	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day	y Year
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٥	res that igned b	by PI	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the c	
ord	w requir been si should I	eted				1 ☐ Yes		/ 4 □Unknown
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tal		e Co	25. Was case relerred to medical		26. Place of I	1 ☐ Yes 2,5 Death (Check only one)	No 1 Yes 2	] No
f Vi	nysicit	To B	examiner? 1 ☐ Yes 2 No Hospital:	Munpatient 2 ER/Outpatie	Other		ce 6 Other (Specify)	
	ding Ph. After the		ZMatural S I criding	ate of Injury Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
Division	Attending Physician: r death. ector: After this certifica by the funeral director,	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	lace of Injury - At home, larm, s uilding, etc. (Specify)		28I. Location (Stree	et and Number or Rural Ro	oute Number,
Div	s after al Dire	Certification;	4 Homicide	uilding, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attentwithin 24 hours after deatl To the Funaral Director: completely filled in by the	Medical (	(Check only 2 Medical Examinar: On t	the best of my knowledge, dea ne basis of examination and/or in manner stated.	th occurred at the time, date and planvestigation, in my opinion, death or	ace, and due to the caus courred at the time, date	se(s) and manner as stated and place, and due to the	d. o cause(s)
	To the To the Complex	Me	29b. Signature and title of certifier	.1	29c. License number	290	. Date signed (Month, Day	Year)
	*		- Chilling Legue	al House offu	NA2148		1/ay 151-	2004
	10		SO Name and address of person who completed Cicardo OSON 2000	Cause of death (Item 23a) (Type Wast Balt Mere	Street Bultime	re, Hoylo	nd 21223	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 4 2004	2. Registrar's Signature	e e	1		

			For State Registrar	State of Mary	land		artment of F			•	giene Reg. No.	2004	15553
	Physici /Medic	an al	1. Decedent's Name (First, Middle, Las Leah F.	Leinso	n					2. Date of De Month May	12 12	2004	3. Time of Death 8:00 A M
	Examin Funeral		4a. Facility Name (If not institution, given Genesis Health Ca 5. Social Security Number 6. S	re Layhill (	yrs. lasi	t birthday)	4b. City, Town, o  Sil  If Under 1 Year  Months Days	ver S	pring	8. Date of Birt (Month, Da	h M	County of Death  Iontgome 9. Birth Cou	
e, Maryland 21215-0036	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other treumatic event. Ite Medical Exam is a must be retified at 2000.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  Maryland  10b. County  Montgom  10c. Street and Number  3227 Bel Pre Rd.  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's Ecopety only highest grave  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last, Herman  19a. Informant's Name/Relationship (Marla Goldberg /  20a. Method of Disposition	12. Was Decedent Ever Armed Forces? 1	in U.S.	16a. Dece (Give life.	Silve	20906 lispanic Orian, Mexicar Specify: lation during most during most during most Je: and Number	ing  gin? (Spece, Puerto R  t of working  ar's Name  nnie  ar or Rural  Green	Aug. 4,  Sify Yes or No- lican, etc.)  g  (First, Middle,  Route Number belt,	1910  10g. Citize  Uni  16b. Kine  Co  Maiden S  Rub  Rub  or, City or	en of What Cou	ates ican Indian, , etc.  White Industry
Baltimore,	permit. Pages 1 Department of F Importent: If ite any injury or ot once.		1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Specification 5 Signature of Fune all Services) in the services of Fune all Services in the services of Fune all Services in the services of Fune all Services in the services in the services of Fune all Services in the services of the serv	Removal from State  y)  isee	King	g Dav	id Cemete Name and Addre Lapp Fune	ery ss of Facili ral a Ave.,	Silv	emationer Spr	Fall n Ser ing,	s Churc	
8760,	Physician and // / / / / / / / / / / / / / / / / /	dical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	tc nsequer tia	Thrince of):		ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
P.O. Box 68	death certifi e attending od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal de	ath 3[	□Ectopic pregnancy □ Other (specify) _	/			23	3d. Date of delive Month	very Day Year
Vital Records, P.	The law requires that the diate has been signed by the page 2 should be detached	Completed by Physic	Part II. Other significant conditions of	contributing to death but no	ot resultin	ng in the u	nderlying cause giv	ren in Part I		1 □ Y	es 2	No 3 □ Pro	the cause of death?  bably 4 □Unknown  opsy findings available ompletion of cause of
Division of Vita	or Attending Physicien: ther death. Director: After this certific in by the funeral director.	Certification: To Be (	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide Getermined	B ORo Blood of Injury	ar) 28	VOutpatier Bb. Time o Injury e, farm, st	f 28c. Injur Wor M 1 □	ier: 4 Ni	ursing Hom 21 No	8d. Describe t	dence 6 now injury		ral Route Number,
<b>.</b>	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical Ce		nysician: To the best of m miner: On the basis of exa and manner stated	amination			pinion, dea		d at the time,	date and p		to the cause(s)
)	4		Descrit Mo		(Item 2	3a) (Type,		7682 Nea	d 01			13,20	
	Sta Regist		Bennett Morrison 31. Date filed (Month, Day, Year) MAY 1 4 2004	2901 Olu B2. Registrar's	Signatur	g	sports	, 00	· , · · ·		ү	1	

Marisa McFarlane Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03164 1- For Amend Item #19b State of Maryland Department of Health and Mental Hygiene 2 0 0 4 Faster Amend item #23a, FFR ME, 6832,6/23/04/68 rtificate of Death Reg. No. DOS 15554 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 10, **Physician** 2004 13. Mc FarlANE MARISA a M 841 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEAR 6 19 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 □ Yrs. 21329 4346 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 Yes 2 No Director Hary hus WINDSON MILL BAIHHGA 10e. Street and Number 10g. Citizen of What Country? 5 MOUNTAIN (FREN TrinibAD- Tobay O Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American & Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 HNo If Yes, Give Year or Dates: Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) other then 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fill and Mental H Be Morgan Me Farlans 2 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21264

Woodcrest Ave.

BNHHC: Revenue 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is rr any injury or other treum QDCs. LEWIS HUNICA 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Town, State 22. Name and Address of Facility CHATTA M- HAM. Trining - Tchayo SAN JUAN PUBLIC 4 Donation 5 Other (Specify) 21. Signatur of Funeral Septice Licensee 52 40 REISTERSHOW KOND Bolhasa, Merylous 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Pnysician oreclamp51a disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 MFetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1⊠Yes 2□No 1 Department 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide To the H. spital within 24 hours a To the Funeral L spital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely

State Registrar 29b. Signatore and title of entitier

who completed cause

9

32. Registrar's Signature

do

31. Date filed (Month, Day)

30 Jume and address of pers

ath (Item 23a) (Type, Print)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

May 11, 2004

111 Penn Street, Baltimore, Maryland 21201

			7.09.0	sentificate of Death	Reg. N	0. 2004 1000,
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  MILDRED MA6LIDT		5 1	ay Year 1203 P M
<i>}</i>	Examin	er	4a. Facility Name (If not institution, give street and number)  ROSEWOOD CENTER  5. Social Security Number  6. Sex  7. Age (In yrs. last birth	4b. City, Town, or Location of Death  Owings Mills M  day) If Under 1 Year   If Under 24 Hrs. 8	Date of Birth	c. County of Death  Baltimore  9. Birthplace (State or Foreign
	Funeral Director		219705658 1 M 2 KF 97 Y	s. Months Days Hours Min.	7-3-1906	Country) MD
	ne Marylan 8e-f show cillied at	ector	MD BALTITORE 10c. City, Town  OWI	V6S MILLS		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	sath with the 23e or 2	Funeral Director	10e. Street and Number 200 KOSCWOOD LOOL  11 Marital Status  12. Was Decedent Ever in U.S.	10f. Zip Code 2117		US  14. Race - American Indian,
036	urs after de el', or item	ρ	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No If Yes 2 No If Yes, Give Year of Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Rice</li> <li>1 ☐ Yes 2 ☐ No Specify:</li> </ul>	can, etc.)	Black, White, etc.  Specify: White
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumetic event, It a Marical Examinant must be notified at	Completed	(Specify only highest grade completed) (	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)  NEVER WORKED	16b.	Kind of Business/Industry  N/A
Maryland 2	should be filed ind Mental Hygi s marked other umetic event, I	To Be Co	17. Father's Name (First, Middle, Last) Harry H. Maglidt	18. Mother's Name (F Katherine		
, Man	1 and 2 sho Health and I sem 27 is ma other treums		Mrs. Jean Price (Daughter) 981	Mailing Address (Street and Number or Rural F O Maglidt Rd. Baltimo	ore, Md.	21234
Baltimore,	permit. Pages 1 Department of He Importent: If iten any injury or oth		1VVBurial 2 Cremation 3 DRemoval from State	Disposition (Name of crematory or other place)  O5/14/0  O5/14/0	2 <del>-04</del> Ba	location - City or Town, State
Balt	permit. Departr Import any inj		21. Signature of Funeral Service Licensee  2. J. Lassaln	22. Name and Address of Facility Lassahn Funeral Home		elair Rd. ore, Md. 21236
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or a by insequence of	liabetes mellitus	espiratory arrest,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and dor use as the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of d.			31
.O. Box 6	it the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
<u>α</u>	es tha	by	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.		ouse contribute to the cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
ion of Vita	Attending Physicien: 1 r death. ector: After this certifical by the funeral director, p	To Be	25. Was case referred to medical examiner?  1	- 17		State Intermediate (ase 6 ther (Spech)) Facility ury occurred
Division	el or Attendi s after death. sl Director: A od in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical (	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.			
	To the within 2 To the complete	Σ	29b. Signature and title of certifief	29c. License number 025001	29d. D	late signed (Month, Day, Year)
177	D		30. Name and address of Serson who completed cause of death (Item 23a) (1	1900 ROWWOOD Ly	Dwing	s Mills MD 21117
	Sta Regist		31. Maryling (Month, Den Koer) 31. Bacistrar's Sjugature	park	,	

			State of Maryland / Department of H  1- State Registrar  State of Maryland / Department of H  Certificate of R	lealth and M Death	lental Hyg	giene 2 (	004	155	56
	Physici	an	1. Decedent's Name (First, Middle, Last)  Frank Clarence Mannel, Sr.		2. Date of Dea Month	Day	Year	3. Time of De	ath
	/Medic Examir			or Location of Death Bel Air	May II	4c. County Harf		0025	
	Funeral Director		5. Social Security Number 220-18-9314 6. Sex 7 7. Age (In yrs. last birthday) If Under 1 Year Months Days  Usual Residence of Decedent	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 17	, Year) , 1926	Coun	lace (State or Fi try) y Land	oreign
	h the Maryland or 28a-f show	ctor	10a. State				1	0d. Inside City L	_
	with the	Director	10e. Street and Number         10f. Zip Code           2002 Stockton Road         21085			10g. Citizen of		•	
0025	1215-UU36 within 72 hours after death with the Maryland ane. than "natural; or Itams 23e or 28e-f show the Medical Examahar must be mailted at	d by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces?	ecify Yes or No- Rican, etc.)	United States  o-				
0 2	Naryland Z1Z15-DU350 2 should be filed within 72 hours alt and Mental Hygiene. is marked other than "natural", or raumatic event, the Medical Exern	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+) 4  Office Manage	during most of working)			lic a tic E		t
	d be fit ental H ked oth	o Be	17. Father's Name (First, Middle, Last) Unknown Mannel	18. Mother's Name Florence			ne)		
	Earylo	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Information of Street and Information o	<u> </u>			State, Zip	Code)	
111/04	Baltimore, Maryland Z1 permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygier Important: If item 27 is marked other th eny injury or other traumatic event, IIII ance.		Mrs. Emilia Mannel/Wife  2002 Stocktor  20a. Method of Disposition 1 Burial 2 Oremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place of Chesapeake Crema	ce) D	oppa, MD Date May 12 2004	21085 20c. Location - Beltsv:			
19	Darmit. F Departme Importar eny injure		21. Signature of Funeral Service Licensee  22. Name and Addres  Cremation		eral Alt	ternati			
1268217	bhysician and potrate be executed with potrate transit the burtat-transit transit tran	dical Examiner	23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ng, such as cardiac o	or respiratory arr	rest,		Approximate Interval Betwee Onset and Dea	n th
#	HECOTOS, P.O. BOX 68  The law requires that the death certifics ate has been signed by the attending progge 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Pregnant at time of death 5   Other (specify)   9   Unknown   1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Fetal death 3   Ectopic pregnancy 1   Vive birth 2   Vive birth 2   Vive birth 2   Vive birth 3   Vive birth 2   Vive birth 3	<i>(</i>			te of delive	ry Day Yea	ī
	COLGS, P. CordS, P. CordS, P. CordS of that the signed by should be detacted.	β	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give conquitors head fully	en in Part I.		bacco use cont		e cause of deat	
rank	VITAI HECOTAS, sician: The law requires to certificate has been signe frector, page 2 should be o	Completed			24a. Was a autops perform	sy med?	prior to con death?	osy findings ava npletion of caus 20 No	ilable e of
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	After fune	cation; T	27. Manner of Death  1 Netural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury World Injury  4 No. 1	y at rk? Yes 2 □ No	28d. Describe h			,	
anne	DIVISION Hospital or Attent 4 hours after deatl Funeral Director: tely filled in by the	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Si City or Town	n, State)			
E	the the	Medical Certification;	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	ppinion, death occurre	ed at the time, d	late and place,	and due to	the cause(s)	
	To To					29d. Date signer	u (Month, L	oay, rear)	
	(ot)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Droved 5 Down 6 5 W. Mo-Sha	50 CM	elan	m	120		
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 4 2004  Secure 4		·	4.)			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** David McDonald 2004 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1026 N. Hollins St. ,Apt.B Baltimore 5. Social Security Number 215-28-5670 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 SC 1 M 2□F Director 74 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28a-f show other traumatic event, the Madical Exampler must be notified at 1 ☐Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1026 N. Hollins St., Apt. B 21223 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. Ih and Mental Hygiene. 7 Is marked other then "ne Hollaway and Son Personal Secondary (0-12) 9 Years College (1-4or 5+) Fork Lift Operator Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be David McDonald Vermel Samuels 19a. Informant's Name/Relationship (Type, PrintDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 s 1 and 2 s of Health an item 27 is 3408 Barilley Woods RD.Randallstown, MD Anne Vickie Saunders 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or Loudon Park 5-16-04 \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Fune al Service Licenses 22. Name and Address of Facility Howell Funeral Home 4600 Liberty Heights Balto., MD, 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician prostat Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy requires that the death in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the P.O. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 should be 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes After this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Magner of Death 28b. Time of Certification; 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0031586 Lausson MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St WD 31. Date filed (Month 32. Pegistrar's Signature Registrar

			1 - For State Registrar	State of Maryland			of Healt		/lental Hy	giene Reg. No	200	4 1551	5.8	
			Decedent's Name (First, Middle, Last,					-	2. Date of De			3. Time of Deat	th	
	Physici /Medio		CAROLYN				OLC	ZAK	MAY	9	y Year 2004		∑M	
	Examir		4a. Facility Name (If not institution, give The Johns Hop  5. Social Security Number 6. Se	olains Hospi	tal	Bal If Under	own, or Locati		8. Date of Bi		n/a	ath rthplace (State or For	nian	
	Funeral Director			M 25xF 81	Yrs.	Months	Days Hou		Jan 3	ay, Year)	(	ryland	Bigiti	
	and w		Usual Residence of Decedent  10a, State 10b, County	10c City	. Town or Lo	cation				- , -	2 2 3 1 2 3 3	10d. Inside City Lin	nits	
	Maryla	tor	Md. n/a		Baltin							1 <b>½</b> Yes 2 □		
	or 28a	)irec	10e. Street and Number			10f. Zip		,		10g. Ci	tizen of What C	ountry?		
	s 23s	rai	147 North Luz				2122				US			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 le marked other than *natural', or items 23e or 28e-f show any injury or other traumatic event, it a Medical Example in Internal Le invilled at ance.	by Funeral Director	11. Marital Status  1 ⅓ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			ent of Hispanic fy Cuban, Mex		ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh Specify: W			
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2121	od within 7 giene. ar than "r	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)			done during i e retired) laker	nost or wor		01	wn Hom	е		
Maryland 21215-0036	should be file nd Mental Hy marked oth amatic event	To Be (	17. Father's Name (First, Middle, Last) unknown						e (First, Middle REESE	, Maider	Sumame)			
Mar	12 sho h and 7 le ma trauma	1	19a. Informant's Name/Relationship (Ty						a <i>l Route Numb</i> Balti					
	Health tam 27 other tr		Phyllis R. Brun	20b. Pla	ace of Dispos	sition (Nam	e of		Dalli		ocation - City o			
altimore,	Pages nent of int: If it iry or o	l j	1 ☐ Burial 2 ♣ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crem VV1 e.W		nerpiace) natory	5/13	2/04	Ba	ltimor	e, Md.		
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	A	22.	Name and	Address of Fa	Kac	zorows	ki 1	Funera	1 Home, P d. 21222		
100	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	cations that caused he death. the cause on each line.  CARDIO GENIC			of dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):									
	P #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. NOTE MOCARDIAL INFARCTION 48 HOURS  any, leading to immediate ause. Enter Underlying ause (Disease or injury)  Due to (or as a consequence of):										
oʻ	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):									
68760	cate be physici s the bu	dicai		ı										
Box	The law requires that the death certificate be executed the has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 3d No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetaf of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 🗌	Ectopic pre Other (spe			23d. Date of delivery Month Day Yea					
P.O.	res that I signed by be deta	y Ph	Part II. Other significant conditions con	tributing to death but not result	ting in the un	iderlying ca	use given in Pa	art I.	23e. Did t	tobacco i	use contribute t	o the cause of death?	?	
ords	w require been sig should b	led b	TOBAGO ARUSE, HYPER	TENSION, HYPER	CHOLES	TEROL	EMIA		1 🔀	Yes 2	□No 3□P	robably 4 Unkno	)WN	
Records,	has be	npie							24a. Was	psy	24b. Were a	utopsy findings availa completion of cause	able of	
									1 ☐ Yes	rmed? 2⊠No	death?	2 No		
Vital	ysician: The is certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ⊠ Inpatient 2 ☐ E	R/Outpatient	: 3□ DOA	04	1000	h <i>Check onl</i> o ome 5 ☐ Resi		e DOthar (Sa	and d		
Division of	neral c		27. Manner of Death 1 ⊠Natural 5 □ Pending		28b. Time of Injury		c. Injury at Work?	ivaising ric	28d. Describe			icity)		
Sio	tendir leath. tor: Al the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2	□No						
N N	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely illied in by the funeral director,	Certification:	4 Homicide determined	28e. Place of fnjury - At hon building, etc. (Specify)	ne, farm, stre	et, factory,	office		28f. Location ( City or To	Street an wn, State	nd Number or R	ural Route Number,		
	n 24 hou he Fune pletely fil	edicai	29a. Certifier (Check only one) 1 ★ Certifying Physical Examination	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred a estigation, i	t the time, date in my opinion,	and place, death occur	and due to the red at the time,	cause(s) date and	and manner a d place, and du	s stated. e to the cause(s)		
	To the To the Comp	Σ	29b. Signature and title of certifier	1.4. x.s		29c.	License numb	er		29d. Da	te signed (Mon	th, Day, Year)		
			. Edizabeth a. Spil				ES-00	0		MAY	9 20	>02		
	8		30. Name and address of person who co			· ·		0-100	al (.)	C- P		ha	07	
W	Sta	te	BLIZARETH A. GRIPFITHS, JOHN 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ITO TOWER	- 110 Doc	rors Loung	AE, GOO	N WOLFE	ST, B	altimore	MARYLAND 217	-8+	
	Registr		MAY 1 4 2004	Render A	4									

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** HENRIETTA PATRICK May 6 2004 3:30 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 214-14-7423 82 Director Virginia 6/17/1921 Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-f show any Injury or other traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Harford DARLINGTON 1 ☐ Yes 2 X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1905 Castleton Road 21034 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. I ☐ Yes 2/∑No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) John Sherman Woods Orphia Ovella Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Ralph G. Patrick/Son 1905 Castleton Road, Darlington, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dublin Southern Cemetery 5/10/04 Darlington, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 The disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Approximate Interval Between Dnset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: The lew requires that the death certificate be executed physicien and s the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditiona contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1□ Yes 2☑No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Ves 2 No 1 ☐ Yes 2 ☐ No ours after death.

•rai Director: After this certific filled in by the funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Medical Certification: To 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) 00060768 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 2/9//, Hi Sup Sim, M.D. Maine St E. Rising San 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

			For State Registrar		tate of M		d / Depa	artmen	t of H	ealth a			giene	9		مرميدي ا	
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i i	Funeral Director		219-86-0441		2 10 F	ga (myra. n	40 Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)	363		ace (State or Forei	gn
			Usual Residence of Decedent									Dec 23	), IS	963	Mary	land	
	how		10a. State 10b. Count	У		10c. City	, Town or Lo	cation							10	d. Inside City Limi	ts
	Ma-fs	ctor	MD N/A			Ba	ltimor	е								1 Pres 2 N	10
	or 28	ire	10e. Street and Number				-	10f. Zip	Code				10g. Cit	izen of Wh	at Count	try?	
	23a unit b	al [	2300 Winder S	treet				212	230				Uni	ted :	State	es	
	r dea	Funeral Director	11. Marital Status	12.	Was Decedent Armed Forces	Ever in U.S	S. 13. \	Vas Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race -	America White, e		
36	be filed within 72 hours after death with the Maryland hat hygiene.  d other than "natural", or flems 23a or 28a-f show event, it a Mudical Examinar must be notified at	by Fu	1 Never Married 2 Ma		1 ☐ Yes 2 ☑ If Yes, Give	No		1 ☐ Yes 2		Specify:				Specify:	vviinto, c	NO.	
Maryland 21215-0036	hour	d b	3 Widowed 4 Divorce		Year or Dates:		10.0							E	Black		_
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0	2 should be filed with and Mental Hygiene. Ie marked other thai aumatic event, Itan	BeC	17. Father's Name (First, Middle	, Last)		1						(First, Middle	, Maiden	Sumame)			
an	ld be lental ked c	To B	William Gree	n						Anni	e H	arrell					
ary	d 2 should I th and Meni 7 le marke traumatic	-	19a. Informant's Name/Relation	ship (Type,	Print)		19b. Mailin	g Address	(Street a			l Route Numb	er, City o	r Town, St	ate, Zip (	Code)	_
	27 EF		Mr. Walter Ph	illips	/Husba	nd						ltimore				•	
e,	of Health		20a. Method of Disposition				ace of Dispo	sition (Nam	ne of			ate		cation - Ci		vn, State	
Ĕ	Pages nent of int: If Its iry or o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (		oval from State		esapea	-				May 12 2004	Bel	tsvil	le.	MD	
Baltimore,	permit. Pages 1 a Department of Her Important: If Item any injury or othe		21. Signatury of Funeral Service	Licensee	4.10	0984	22	Name and	d Addres	s of Facility	v	10/5					
Ω	Deg du y		Ho	tell	700	-		8717	Gree	and n Pas	rune sture	eral Al es Driv		ative altim		MD	
-			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complication	ons that cause	d the death	. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,	WI CIN		Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition		Thra	h h	C Th	rom	holl	Ulma	100	Die				Onset and Death	
	/Medical		resulting in death)	a	Due to (or as			CITATI	DCC	101	CILL	Lion	D CA C	4	-		_
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	ν <del>π</del>	je i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as	a consequ	ence of):										
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×	death certificate e attending phy id for use as the	Physician/Medi	IF FEMALE:	230 1	f yes, outcome	of pregnan	NOV.										
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?		1 ☐Live birth 4 ☐ Pregnant a	2 Fetal	death 3 🗆	Ectopic pre					2	23d. Date o Month		y Day Year	
P.O.	0 0 0	ıysi	1 ☐ Yes 2 ☐ No 9 ☑ Unknown		9 Unknown	t title of de	a(i) 5	Other (spe	<del>-</del> City)								
	requires that the een signed by th hould be detache	4 7	Part II. Other significant condit	ons contribu	uting to death b	ut not resul	iting in the un	derlying ca	use give	n in Part I.		23e. Did to	obacco u	se contribu	ite to the	cause of death?	
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Be	The law ate has b page 2 s	mc							-		_	autop		prio dea	r to comp th?	sy findings available pletion of cause of	6
ta		Ö	25. Was case referred to medica	, T						00 Dises	of Death	1 Yes				⊠No	
5		ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospi	ital: 1 🔯 lonatio	ant 2 TE	R/Outpatient	3[] DO/	Other			(Check only o		Clou			
0	p Physer this eral di		27. Manner of Death	21	Ba. Date of Inju	ry :	28b. Time of		c. Injury Work			ne 5 🗆 Resid			Specify)		_
<u>.</u>	Attending ir death. ector: After by the funer	atio	1 Natural 5 Pendi 2 Accident invest	ng igation	(Month, Da	y Year)	Injury	М		? es 2	lo						
Division of Vital Records,	Attendia or death. ector: A by the fu	ifica	3 Suicide 6 Could 4 Homicide determ		8e. Place of Inj	ury - At hon	ne, farm, stre	et, factory,	office		2	8f. Location (S	Street and	d Number o	or Rural I	Route Number,	-
Ö	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4   Homeda		building, et	с. (Зреспу)						City or Tow	m, State)				
	Hospital     24 hours a     Funeral E     letely filled i		29a. Certifier 10 Certifyi	ng Physicia	n: To the best	of my know	ledge, death	occurred a	t the time	, date and	l place, a	nd due to the d	cause(s)	and manne	er as stat	ed.	
	n 24 he Fi	edicai	(Check only 2 Medical one)	Examiner:	On the basis o and manner st	r examinatio	on and/or inv	estigation,	in my opi	nion, death	n occurre	d at the time, o	date and	place, and	due to the	he cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certific						License			:	29d. Date	signed (A	fonth, Da	ay, Year)	
			Ma Ma	rkes	Me	dical	Resid	unt	#p	1763	58		MI	cy,10	0,2	004	
	10		30. Name and address of person						0			2 :		1 :			
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	Sta		31. Date filed (Month, Day, Year		32. Registr	ar's Signatu	ire										
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DHN	/IH 17 Rev 1/20	001		1.		100	OPICINI	certs									
						(	ORIGIN/	1L									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY  $1^{\text{Day}}$ , **Physician** 6:50 pM 2004 CATHERINE PARZYNSKI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3123 FAIT AVENUE N/ABALTIMORE 8. Date of Birth (Month, Day, Year) 10/29/11 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🔏 F Yrs. 92 MARYLAND Director 212-07-4337 Usual Residence of Decedent 10d. Inside City Limits the Manyland 10a. State 10c. City, Town or Location 28a-f ahow the Medical Examiner must be notified at 1 KYes 2 No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 3123 FAIT AVENUE 21224 USA Items 23a death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ner any injury or other traumatic avent. It a Mudical Exam 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 250 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 SNo Specify: Specify þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PACKING HOUSE PACKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY MICHAEL CHOJNACKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MD. 21224 MR. ADOLPH LINDEMANN 2419 FAIT AVENUE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State STANISLAUS CEME. 5/14/04 BALTIMORE, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KACZOROWSKICHTUNERAL HOME P.A. Robert he STREET BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LONGES **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ₩ 10 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ٥ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Harknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2₽ No 1 Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3□ DOA Medical Certification: To 1 Yes 2 No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 -Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

Registrar DHMH 17 Rev 1/2001

State

3509 32 Deglatrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (No Day, Yalar) 2004

DO

H43234

Av, Baltimore

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			1 - State Registrar	State of Marylan	d / Depa		ealth and M	lental Hygi			
	Physic /Medi	cal	Decedent's Name (First, Middle, Las     Carlos Dea	n Rushing, Sı	r.	4b. City, Town, or	Location of Death	2, Date of Death Month May 1	Day Year  1 2004  4c. County of De	2:30 a M	
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give  15620 Bond Mill  5. Social Security Number  216-30-4054	Road	ast birthday) Yrs.	Lau If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept. 9	Prince (		
21215-0036	72 hours after death with the Maryland naturel, or fems 23a or 28a-f show licel Examiner must be notified at	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD Prince (  10e. Street and Number  15620 Bond Mill  11. Marital Status  1 Never Married Marned  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grace)  Elementary/Secondary (0-12)  8 th	George's L  Road  12. Was Decedent Ever in U. Armed Forces? 12. Wes 2 □ No If Yes, Give Year or Dates: 19	s. 13.1 52- 16a. Deced	cation  10f. Zip Code 20707  Was Decedent of His 1 Yes, specify Cubar 1 Yes 2XX  Jent's Usual Occupa kind of work done d DO NOT use retired) ine Opera	spanic Origin? (Spe h, Mexican, Puento Specify: tion uring most of works	ocify Yes or No-Rican, etc.)	Og. Citizen of What C USA  14. Race - Am Black, Wh Specify: V  6b. Kind of Busines Plastic I	10d. Inside City Limits  1 Yes 2 No  Country?  Therican Indian, lite, etc.  White	
Maryland	12 should be filed within: h and Mental Hygiene. 7 Is marked other than "I traumatic event, the Max	To Be	17. Father's Name (First, Middle, Last)  Alfred Rushing  19a. Informant's Name/Relationship (7)  Portha Dughing (Middle)	ype, Print)		ng Address (Street a	nd Number or Rura	Mae Newt	ton City or Town, State, Zip Code)		
Baltimore, I	permit. Peges 1 and Department of Health Important: If item 23 any injury or other t		Bertha Rushing/Will  20a. Method of Disposition  **PSurial 2   Cremation 3    **4   Donation 5   Other (Specify  21. Signature of Funeral Service Licenses)	Removal from State 20b. P	lace of Dispo emetery, cren vage C	sition (Name of matory or other place emetery Name and Addres	5/13/ s of Facility Do	/2004 Sonaldson	Oc. Location - City of Savage, MI	Town, State  O  Home, P.A.	
8760,	Certificate be executed  Adding physician and the purial-transit as as the burial-transit and the purial-transit a	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Amyotrophic Lateral Sclerosis  Due to (or as a consequence of):							Approximate Interval Between Onset and Death 8 Years		
P.O. Box 68	death e atter	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of do	elivery Day Year	
	requires een sign hould be	Completed by Ph	Part II. Other significant conditions co Coronary Arto	ery Disease	ulting in the u	nderlying cause give	n in Part I.	1 🗆 Yes	s 2 [X]No 3 ☐ F	to the cause of death? Probably 4 ∐Unknown	
ital Rec	ian: The law intificate has b stor, page 2 sl	Be Comple	Hyperlipoider Hypertension 25. Was case referred to medical	nia			26. Place of Death		ed? death? ∑No 1 ☐ Ye	autopsy findings available completion of cause of	
O L 27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Nork?							at ? 'es 2 No	28d. Describe hov	eet and Number or F	ecify) Rural Route Number,	
	o the Hospitel ithin 24 hours o the Funerel ompletely filled	Medical C	29a. Certifier (Check only one)  2   Medical Exam	/sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the tim- vestigation, in my op	inion, death occurr	ed at the time, da	use(s) and manner a te and place, and du d. Date signed (Mon	e to the cause(s)	
	15*1	ate	30. Name and address of person who of Raymond E. B. 31. Date liled (Month, Day, Year)	0.0	71 Gor		36371 Laurel,		5/11/0		
	Regist		MAY 1 4 2004	Beneva	4	1					

ORIGINAL

			State of Maryland / Department of State Amend Item #1 per me G832 6/11/14 tas Per FH G832,6/3 <b>Ceow</b> icateC6		•	•	15563
	Physici	ian	1. Dacedent's Name (First, Middle, Last) Eugene Streeter Jr.		2. Date of Death Month	Day Year 2004	3. Time of Death 9:48 P M
	/Medic Examir			or Location of Death	MAI 10,	4c. County of Death	9:40 P
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex Months Day:		8. Date of Birth 5	/27/779. Birthpl Coun Mar	ace (State or Foreign try)
	tryland show	_	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location			10	Od. Inside City Limits
	r 28e-f	irecto	10e. Street and Number		10g.	Citizen of What Coun	1 <b>A</b> es 2 □ No try?
	eath with	erai D	1401 E · 254 Street 212  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	Hispanic Origin? (Spe	city Voe or No.	14. Race - America	en Indian
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23e or 28e-f show or other treumetic event, the Medical Exam	by Funeral Director		iban, Mexican, Puerto F	Rican, etc.)	Black, White, e	ack
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Maryland	2 should be filed within 72 hours aft and Mental Hyglene. is marked other than "naturel", or eumetic event, the Mudical Even.	To Be	Fugere Streeter Sk:	18. Mother's Name	(First, Middle, Maid	Lout	
Man	and 2 sho salth and I n 27 is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Streeter Se: (Faller) 110. N. Print)	et and Number or Rural	Route Number, Ci	ty or Town, State, Zip	Code)
ore,	ges 1 and it of Health If item 27 or other trees.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b Place of Disposition (Name of cemetery, crematory or other place)		ate 20c	. Location - City or To	wn, State
Baltimore,	permit. Pages Department of Importent: If i eny injury or o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  12. Agme and Add	responsacility and	104 Da	Hinory/	WD Tes
B	8358		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of the	on Pa	Bulko . respiratory arrest,	ND 21212	Approximate
	Physician	7 7	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	& hose	)		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  D e to (or as a consequence of):				
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
,00	ate be executed hysician and the burial-transit		that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
68760	ifficate b g physic as the b	ledical	d				
). Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify).	су		23d. Date of deliver Month	y Day Year
s, P.O	uires that the de signed by the a d be detached f	by Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	oven in Part I.	23e. Did tobacc	o use contribute to the	a cause of death?
ecords,	w requir been si should	Completed			1 ☐ Yes 24a. Was an		sy findings available
$\alpha$		Comp			autopsy performed 1 Yes 2	prior to com	pletion of cause of
f Vital	ding Physicien:  After this certification of the director.	To Be	25. Was case referred to medical examiner?  1 ★ Yes 2 □ No  Hospital: 1 □ Inpatient 2 ★ EP/Outpatient 3 □ DOA ○	26. Place of Death ther: 4 ☐ Nursing Hom		6 □Other (Specify)	-
on of	Jing J. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury With Injury  28c. Injury With Injury  28c. Injury With Injury With Injury  28c. Injury With Injury With Injury  28c. Injury With Injury With Injury With Injury  28c. Injury With In		8d. Describe how in		+
Division	or Attending after death. Director: After	Certification:	2 Accident 3 Suicide 4 Homicide  Outland not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	/	Bf. Location (Street Chy or T wn, St	and Number of Rural	Route Number,
~	To the Rospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the axion on the basis of examination and/or investigation, in my and manner stated.	time, date and place, as opinion, death occurre	nd due to the cause d at the time, date a	o(s) and manner as sta and place, and due to	ited. the cause(s)
ĺ	To the within 2 Comple	Me		nse number		Date signed (Month, D	
	1		30. Henre and address of person who completed cause of death (Item 23a) (Type, Print)	CME		1AY 11, 200	
	Sta	ate.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Penn Street	, Baltimo	ore, Maryla	and 21201
A	Regist		MAY 1 4 2004 Server B sports				

				For State Registrar	State of	f Marylan		artmen <i>rtificat</i>			nd Me		giene Reg. No. 2	004	15564
				Decedent's Name (First, Middle, Last)							1	2. Date of Dea Month		Year	3. Time of Death
		Physicia /Medic		Walter J. Steffens	, Sr.						1	1ay	12	2004	2:30 A. <sup>M</sup>
	}	Examin		4a. Facility Name (If not institution, give st	reet and nur	mber)		4b. City,	Town, or	Location of	Death		4c. Cou	inty of Death	
				113 Park Drive			1	If I loder		nsvil If Under 2		Date of Bird		altimo	
		Funeral		5. Social Security Number 6. Sex	M 2□F	7. Age (In yrs.	iast birtnday) Yrs.	Months	Days	Hours	Min.	B. Date of Birtl (Month, Day 06/28/1	(, Year)	Cour	
		Director		212-30-5812 Superior State of December 1		72						J0/20/1	.931	M	υ
		show		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						1	0d. Inside City Limits
		Mar.	tor	MD Baltimore	:		Cat	onsvi	.11e						1 ☐ Yes 2 X No
		or 28	lre	10e. Street and Number				10f. Zip	Code				10g. Citiz <i>e</i> n	of What Cour	ntry?
A		death with the Maryland ims 23s or 28s-f show	Funeral Director	113 Park Drive						1228				USA	
4		tems tems	nue	11. Maritar Oratos	Armed Fo		.S. 13.	Was Dece If Yes, spe	dent of His cify Cubar	spanic Orig n, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)	14.1	Race - Americ Black, White,	
Lord	36	rs after death with the Maryla I', or items 23a or 28a-f show Kuriluer invertibe modified at	by F	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	/e _		1 ☐ Yes	2 <b>X</b> No	Specify:			Spe	city:	White
F	5-0036	within 72 hours after ene. then "natural", or ite na Mcdlcal Extrrition	ted	15. Decedent's Educ	ation		16a. Dece	dent's Usu	al Occupa	tion			16b. Kind o	f Business/In	
3	215	hin 72	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed)	1-4or 5+)	life.	DO NOT u	rk done d se retired)	uring most	or working	9			
	21	giene. er then the M	Completed	12	2			Bank	er					ancial	
00	pu	be filed ital Hygir d other event, I	Be (	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden Sur	name) *	
2	yla	should be filed with and Mental Hygiene is marked other the aumatic event, Ing.	2	Walter Steffens	01.4		405 44-75		(0)		ces 2	Zenk Route Numbe	City or To	State 7in	Cadal
Walter	Maryland			19a. Informant's Name/Relationship (Typ											(Code)
3				Ann Steffens/ Wife 20a. Method of Disposition		20b. F	Place of Dispo	Park	ne of		Da	nore, N		∠O on - City or To	own, State
3	Б	Pages nent of h int: If its ury or o		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from	State	don Pa	-			5/15	/2004	Ba1t	imore,	MD
	altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service License		рыси						wab Fur			
	Ba	Dep Pen Suny	7.7	VLa le Klike	6)		7	terli 36 Ec	.ng A lmond	snton son A	sch ve.	wab Fur Baltin	neral	ноте, MD 212	28
	Ψ			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that o	caused the deat	h. Do not en	ter the mod	le of dying	such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	Λ	netos	tatio	- 1	une	9 (	Can	cev			Onset and Death
		/Medical		resulting in death)	Due to	(or as a conseq	uence of):				- ,,		-		111011111
	и	Examiner		Sequentially list conditions, b.											
		be disit	line	cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence ot):								
		xecut and al-trar	Examiner	that initiated events c. resulting in death) Last	ot eud	(or as a conseq	juence of):								
	Box 68760,	ate be executed thysician and the burial-transit	<u>a</u>	l d											_
	89	tificate ng phy as the	edic												
	ŏ	eath certifics attending pl for use as t	an/Med	230. was decedent pregnant		tcome of pregna		⊒Ectopic p	regnancy				23d.	Date of delive	-
		ne death the atte	7	in the past 12 months? 1 Yes 2 No		nant at time of c		Other (s						Month	Day Year
	P.O.	that the ded	Physi	9 Unknown			ultina in the	and articles		n in Dark I		23a Did to	phaceo use	contribute to t	he cause of death?
		ires thai signed t d be det	b	Part II. Other significant conditions con	ributing to a	eath out not res	suiting in the t	andenying (	ause give	nın Fanı.			es 2□N		
	Ö	v requir	etec									24a. Was	an 2	4b. Were auto	ppsy findings available
	Rec	he law e has ige 2 t	ompleted									autop	rmed?	prior to co death?	mpletion of cause of
	ā	ysician: The is certificate hadirector, page	e Co	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2   NO
	>	ysicia s cert direct	OB	avaminar?	ospital:	Inpatient 2	ER/Outpatie	nt 3□ D	OA Othe		rsing Hom			Other (Specif	( <b>y</b> )
	0	ding Phys h. After this funeral di	T:u	27. Manner of eath	28a. Date (Mon	of Injury oth, Day Year)	28b. Time o	of :	28c. Injury Work	at ?	2	8d. Describe h	now injury oc	curred	
	Ö	death. ctor: Af y the fur	atio	1 Natural 5 Pending investigation				М		res 2 □ N					
	Division of Vital Records,	or Att tter de directe n by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined		e of Injury - At h ling, etc. <i>(Speci</i>		treet, factor	y, office		2	8f. Location (S City or Tox	Street and No vn, State)	umber or Rura	al Route Number,
		pital ours al	_	29a. Certifier Certifying Phys	ician: To the	a bact of my kn	owledge dea	th occurred	at the tim	e date and	d place a	nd due to the	rause(s) and	l manner as s	tated
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examin	er; On the b	pasis of examination of stated.	ation and/or in	nvestigation	n, in my op	inion, deat	th occurre	d at the time,	date and pla	ce, and due to	o the cause(s)
		To th withir To th comp	Me	29b. Signature and titlenof certifier	11	1 100	1	29	c. License	-	07			gned (Month,	
	P	7/10		parlio	onn	reg m.			DI	87	8 +		MAY	13.	2004
		7		11.	mpleted cau	se of death the	m 23a) (Type	Print)	A	UB	3,	ALTIM	INE	Mi	2004
		Sta Regist	ate rar	31. Date file (Moch, Pay, Year) MAY 1 4 2004	3º	Registrar's Sign	ature	Loa			-				

04-03		t	Stewart Sr. Please	State of Ma	arvland / Det	partment of Health a	ind Mental Hyd	giene 2004	15565
TJD			- Stata Unpend Item Registrar		1,27,2000	ertificate or Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, La Somuel Ro.	Bert Ste	wart,	Sr.	Month Ma	ay 04 - 2004	1023a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, given	re street and number)	,	4b. City, Town, or Location of	f Death	4c. County of Deat	<b>7</b>
h2°	Funeral		,	Sex 7. Ag	e (In yrs. last birthda Yrs.	Baltimore y) If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birt Min. (Month, Da	n, Year) 9. Birt 1932 5. C	hplace (State or Foreign untry)
3	Director	4	Usual Residence of Decedent		//		OU sy	1/32 5 0	muna
	death with the Maryland ims 23a or 28a-f show r nust be notified at	2	10a. State 10b. County	1.	10c. City, Town or				10d. Inside City Limits 1 💇 es 2 □ No
	the M	Director	10e. Street and Number	14	1501	10f. Zip Code		10g. Citizen of What Co	untry?
	th with		2812 BENEW	Aro		21215	•	USA	
	r deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1:	Was Decedent of Hispanic Original Street     Was Specify Cuban, Mexican	gin? (Specify Yes or No., Puerto Rican, etc.)	14. Race - Ame Black, White	
36	irs afte	by Fi	1 Never Married 2 Married  Nidowed 4 Divorced	If Yes, Give Year or Dates	NOKOVEM	1 ☐ Yes 2 ☐No Specify:		Specify:	ack
21215-0036	72 hou natura ical E	ted	15. Decedent's E	ducation		cedent's Usual Occupation ve kind of work done during most . DO NOT use retired)	of working	16b. Kind of Business/	10.4
121	ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+1		, -	BEHLELEN	14.1
9 9	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Las.	t)	41661	18. Mothe	r's Name (First, Middle,		0/20
an	Aental rked o	To B	HOSES Stews	rt	A	REB	ECCA DA	vis	
Maryland	2 should have and have is man		19a. Informant's Name/Relationship	(Type, Print)	/	iling Address (Street and Number	r or Rural Route Numbe	r, City or Town, State, 2	Zip Code)
, S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene. Department of Healih and Mental Hygiene.  The Marylan and Mental Hygiene.  The Marylan I the 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic avant, lite Marylan Evan har must be notified at once.	_	20a. Method of Disposition	wort, Vr.		position (Name of	Date / Date	20c. Location - City or	Town State
Baltimore,	ages int of H		Surial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Special Control of Contro		cemetery, c	rematory or other place)	5/11/04	Scinss M.	. /
alti.	mit. P partme cortan injur.		21. Signature of Funeral Service			22. Name and Address of Facility	y Chipman		Dien Hine-
<u>~</u>	Depar Impou any ir		Deray Ler	à		5240 KeisTens	Hun Rd	Bothung 10	
			23a. Part . Enter the disease, or constock, or heart failure. List only	one cause on each lin	ne.	onter the mode of dying, such as oronary ARtery			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a With Hyp	pertensive ( a consequence of):	Atheroscleroti	c Cardiovas	ASSOCIATED Scular Dise	ase
	Examiner			Due to (or as	a consequence or):				
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):				
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				
	sician buria	ल		2 d	<u> </u>				
687	death certificate I e attending physi od for use as the b	Physician/Medic		_ u.					
Вох	th cert tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant is the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 □Ectopic pregnancy		23d. Date of del	ivery Day Year
О.	the at thed fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death	5 Other (specify)		North	Day
, P.O.	n requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	quires an sign	ed by	Head Injury And I	≀ight Femur	Fracture		1 🗆 1	′es 2□No 3□Pr	obably 4 X Unknown
000	law reas bee	piet					24a. Was		topsy findings available completion of cause of
Ä	The law cate has page 2 %	Completed						rmed? death? 2 No 1 X Yes	2 No
Vita	Phyelcian: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Othor	of Death (Check only o		-14.)
of	g Phye er this eral di	<b>—</b>	1 Ves 2 No 27. Manner of Death	28a. Date of Inju	ury 28b. Time	of 28c. Injury at	rsing Home 5 Resid	now injury occurred	erry)
ion	Attanding Ir death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	May 2. 2	21		TATIOTI AND		
Division of Vital Records,	al or Attandii s after death. si Director: A sd in by the fu	Certification:	3 Suicide 6 Could not determined	building, et	jury - At home, farm, tc. (Specify)	street, factory, office		Street and Number or Runn, State) 2812 0	swego Ave.,
	To tha Hospital or Atta within 24 hours after de To tha Funaral Directo completely filled in by th				of my knowledge, de	eath occurred at the time, date an investigation, in my opinion, dea		cause(s) and manner as	
	tha H thin 24 tha F mplete	Medicai	29b. Signature and title of certifier	and manner sta		29c. License number		29d. Date signed (Month	
	F ≥ F 8		I king his. n	4.5		OCME		May 05,	2004
			30. Name and address of person who		death (Item 23a) (Typ			1.5.1111	
			LING LI. M		rar's Signatura	111 Penn Stre	et, Baltimo	ore, Maryla	nd 21201
- 8	Sta Registi	· 24	31. Date filed (Month, Day, Year)  MAY 1 4 2		rar's Signature	lande			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month JEAN ELIZABETH STARLIPER 2004 May 7, 7:25 am 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WASHINGTON BOONSBORO REEDERS NURSING HOME 8. Date of Birth (Month, Day, JULY 2, 1 Birthplace (State or Foreign Country)
 WEST VIRGINIA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 1 □ M 2 X F Months 82 232-26-7655 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No MARTINSBURG BERKELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25401 54 NATHANIEL DRIVE USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) TERZA KLINE CLARENCE MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 NATHANIEL DR., MARTINSBURG, WV 25401 DANIEL STARLIPER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MARTINSBURG, WV ROSEDALE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 10, 2004 22. Name and Address of Facility
BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST.,
WARTINSBURG, WV 25402
Approx 21. Signature of Funeral Service Licensee m ales Diawa Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) 12 haco Dr. nelwork L / Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): es, outcome of pregnancy Live birth 2 D Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? ☐ Yes 2☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Directo

by Funeral

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 Is marked other than "naturel", or items 23a or 28a-f show any njurry or other traumatic event, the Medical Examinat must be notified at once.

Maryland 21215-0036

Baltimore,

Starliper

Examiner and by Physician/Medical jo ed by the a ed bluods Be Completed page 2 s director Medical Certification; To this within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral of

1 Natural

2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed

To the

P.O. Box 68760,

Records,

Division of Vital

	d
F FEMALE:  13b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If ye 1 4 9

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 1
 24a. V

140	3 1 TODADIY	4 POTIKITOWIT
24b.	Were autopsy fi	ndings available

	24a. Was an autopsy performed?  1 Yes 2 No
26. Place of Death (C	Check only one)

b.	Were auto prior to co death?	psy finding mpletion o	gs available f cause of
		2□ No	

25. Was case referred to medical		
examiner? 1 ☐ Yes 2 ☐ No	Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 🗆 D
27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	1

nt 2	3□ DOA	
y Year)	28b. Time of	28c.

28c.	Injury at Work?	
	4 🗆 🗸	

Nursing H	lome	5 Residence	6 ☐Other (Specify)
	28d.	Describe how in	jury occurred
c 3 □No	1		

3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)
29a. Certifier	1 Certifying Phys	icien: To the best of my knowledge, de

	М	1 🗌 Yes	2 🗆 N	
farm, stre	et. factor	v. office		

28f. Location (Street end Number or Rural Route Number, City or Town, State)

	one)				
29b.	Signature	and	title	of certifier	

	sicien: To the best of my knowledge, death occ ner: On the basis of examination and/or investig and manner stated.		
title of certifier /	,	29c. License number	29d. Date signed (Month, Day, Year)

301-432-2222

UD.	oignataro ana		/ 1		
	N	Byn	11 1	MI	2
		Mohn	The state of	6.66	
		0/ /	-,	/	

5 Pending investigation

1032518

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Guedenet,

21 Wyand Dr., Keedysville, MD 21756

State Registrar

		4	For State Registrar	State of Maryland		irtment of F			giene 10g. No. 20	04	15567
	Physici	an	1. Decedent's Name (First, Middle, Last)	nons				2. Date of Dea	th Day	Year OO4	3. Time of Death 8:27 PM
	/Medic Examin	er	4a. Facility Name (If hot institution, give	street and number)	Cent	4b. City, Town, o	Button of Dea	OVE S. 8 Date of Birth	4c. County o	4	ace (State or Foreign
	Funeral Director		212-56-0631	M 20 53	Yrs.	Months Days	Hours Mir	May 16,	, Year)	Count Mary	ry)
	Maryland -f ahow fied at	tor	10a. State 10b. County  MD Prince Ge		Town or Lo	cation				10	Od. Inside City Limits
	with the la or 28e I be noti	I Direc	10e. Street and Number 310 Thomas Drive	Apt. 3		10f. Zip Code 20707	,		10g. Citizen of W USA	hat Count	try?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23a or 28e-f ahow other traumatic event, the Medical Examine man be natified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	'	Was Decedent of his fixes, specify Cub	dispanic Origin? (an, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)		- America k. White, e	etc.
Baltimore, Maryland 21215-0036	within 72 hou ene. than "natura ise Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) Grade 10		(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of w	rorking	16b. Kind of Bu		ustry
and 2	d be filed withing the solution of the solutio	Be	17. Father's Name (First, Middle, Last) Julian Wallace Bru	ıce	1101	nemaker_		ame (First, Middle, een Viole	Maiden Sumam		
Aary	2 should be and Mental is marked o rsumatic eve	ဥ	19a. Informant's Name/Relationship (Ty					Rural Route Numbe			
nore, N			George Simmons, J1  20a. Method of Disposition  1  Surial 2	20b. Plac cen	ce of Disponetery, crer	sition (Name of matory or other pla	сө)	Date 18, 200	20c. Location -	City or To	wn, State
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		27	Name and Addre	ss of Facility Funera	l Home, P le Laure	.A.		20707
	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. Light only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. the cause on each line.  3. Due to (or as a conseque	Do not ent	er the mode of dyli	ng, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	titial	pneu	monitie	5		ļ
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۵	uires that t signed by Id be detac	þ	Part II. Other significant conditions co	ntributing to death but not result	ing in the u	nderlying cause gr	ven in Part I.			ibute to th	e cause of death?
Vital Records,		Completed						24a. Was autop perfor 1 □ Yes	med2 d	rior to con leath?	osy findings available inpletion of cause of
Vita	sician: certific rector.	Be	25. Was case referred to medical examiner?	lospital:	R/Outpatier	nt 3 DOA Ot	bar	eath (Check only on Home 5 Resid		e /Cnast	
o	ding Alter fune	ation: To	1 Yes 2 No  27. Manner of Death 12 Natural 5 Pending 2 Accident investigation		8b. Time o Injury	f 28c. Inju Wo		_	ow injury occurre		/
Division	To the Hospital or Attendwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rura	l Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directional Completely filled in by	edical		sician: To the best of my knowledge.  ner: On the basis of examination and manner stated.							
	To th within To th	Me	29b. Signature and title of certifier	MD		29c. Licen			29d. Date signed May 1	(Month, 1	Day, Year)
	6		30. Name and address of pers in wood Well SSA Waw go	MD 22-8		M19 Greene	Stree	+, Batt	imore	, M	aryland
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32, Registrar's Signatu		land.	,				U

Physic	ian	1. Decedent's Name (First, Middle Charles	le, Last)		ς.	liedt	50	2. Date of De. Month	Day	Year	3. Time of Death	
/Med Exami	ical	4a. Facility Name (If not institution			1	4b. City, Town, o	r Location of Deat	May	13 4c. (	200 County of Dea	7	
		Johns Hopkins 5. Social Security Number	Bayvieu	7. Age (In yrs.		Balt If Under 1 Year	imore	9 Date of Rid	th	n/a	theless (Ctata as Forni	
Funeral Director		215-30-0167	1 MM 2 □ F	7.0		Months Days	Hours Min.	8. Date of Bird (Month, Da 9/18	/ 33	MA	thplace (State or Forei puntry) RYLAND	
and w		Usual Residence of Decedent  10a. State 10b. County	1	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limit	
be filed within 72 hours after death with the Maryland ital Hyglene. d other then "netural", or Items 23a or 28a-1 show event, I've Medical Evaria, er munt be trydified at	to	MD N/A B				BALTIMORE				1 <b>%</b> Yes 2 □ N		
	Director	10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?				
		6728 BOSTON AVENUE  11. Marital Status  12. Was Decedent Ever in			21222				USA 'es or No- 14. Race - American Indian,			
	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	ried Armed Fo	orces? 2 🗌 No		Was Decedent of HIf Yes, specify Cub 1 ☐ Yes 2 ☑ No		to Rican, etc.)		Black, Whit		
	Completed	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business/Industry			
	dmo	Elementary/Secondary (0-12)	College (			DO NOT use retire	,		RF	тн ст	FFI	
	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name			me (First, Middle,	BETH STEEL  a (First, Middle, Maiden Sumame)			
Menta Menta arked aric ev	To B	CHARLES J. KALIBODA			_	EVELYN MIS			KIMON			
and raum		19a. Informant's Name/Relations										
f Healti item 2 other 1		MRS. ELEANOR  20a. Method of Disposition	SLLIEDI	20b. F	20b. Place of Disposition (Name of cometery, crematory or other place)  20c. Location - City or Town, State							
e ° = 5		1 St Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify)  OAK LAWN CEMETERY 5/15/04  BALTIN							TMORE	MD.		
permit. Pag Department Important: any Injury once.			, ,,					3,0.			, 112 •	
OF F		23a. Part 1. Erner the disease, p shock, or heart failure. Li-	r complications that of	A Locaused the deat each line.	K. J	ACZORÓW 201 DUN ter the mode of dyin	DAIJK AV ng, such as cardia	F. BAL	TIMO		D. 21222 Approximate Interval Between Onset and Death	
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Registrar

State

Spark

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** - YNN MA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RANDALISTOWN NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 XF 57 Director 10 16 NY 063-38-8005 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or Itams 23e or 28a-f ahow The Medical Examinar must be nutified at 1 ☐ Yes 2 X No Director MD Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21133 U.S.A. 9817 Winands Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ ★0 If Yes, Give filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify Specify: Black Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygene. Important: If item 27 is marked other than "na any Injury or other traumatic avent, Ite Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) Postal Services 12th grade Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eleanor Sheppard ပ Clifton Metz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 311 Winston Ave, Baltimore, Md 21212 Michelle Warner-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 5/15/04 Randallstown, Md \* 4 ☐ Donation 5 ☐ Other (Specify) March F/H West 4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart full re. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE SCLEROSIS ADVANCED **Physician** /Medical Due to (or as a consequence of) Examiner S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760, physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ sign be ERTENSION , SEIZURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ Nb 24a. Was an page 2 s autopsy performed? certificate 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 ☑No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Cate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division Hospital or Attending 5 Pending Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation by the hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direcompletely filled in br 1) Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[A Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 17333 MAY 6, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVI MA NHC, SAMO, MO 21133 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) **Physician** 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Deeth Fecility Name (If not iperitution, give street and number) **Examiner** NIA Baltimore HOSDICE tchie Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Last birthday) ecurity Number 6. Sex Days **Funeral** Months Hours Min. 1 M 2 B 3560 Marylana Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Show 10b. County ?7 is marked other than "natural", or Itams 23s or 28s-f shov traumatic avent, the Medical Examiner must be multified at 1 Nes 2 No Baltimore NIA Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1235 USA 21229 Kevin Rd. death Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 PNo If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 ie markad other than "natural", or Item any injury or other traumatic avent, the Medical Exemination. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker etary 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Be Pratt Sample James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rd. Balto. 1235 mo father 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Methed of Disposition 1 Ø Burial 2 ☐ Gremation 3 ☐ Removal from State Randallstown mo King Memorial Park 5-14-04 \* 4 □ Donation / S □ Other (Specify) 21. Signature of Aneral Service Licens 22. Name and Address of Facility H870 Fredhilton Pass Ballo, MO 21229 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or part failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or andition resulting in death) VV 9 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? certificate has been signed by the attering the control of the con 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one in by the funeral director. 25. Was case reterred to medical Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes 2 1 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death after death. Certification: Injury 1 Natural 2 Accident 5 Pending 2 🗌 No investigation 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours aft
To the Funeral Di
completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Ligense number 290

State Registrar

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havere SAMPle

31. Date filed (Month, Day, Year) MAY 1 4 2004

RANANDAKNTSHNAN 821 32. Registrar's Signature AS BOOK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIEUTAN 17

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Bernadette 1:18 4 M May 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner City Baltomore Bay New Medical NIA Hopkins Center If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 57 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country), **Funeral** Year) Days Hours 314-46-0752 1 M 2 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "naturel", or items 23a or 28e-f show injury or other treumatic event, It a Medical Examination must be notified at Baltimore 1 Tes 2 □ No Directo NIA MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iter any injury or other treumatic event, If a Medical Examinal once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home ousewife 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ireland 19a. Inform: t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Balto. 6 21201 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 1 remation 3 Removal from State Catonsville, 4 □ Donation S Other (Specify)

21. Signature of Service Licenses Crematory 14 240 Fredhilton Pass Bato, MS 21229 me 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, whart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acidosis hours /Medical Due to (or as a consequence of): **Examiner** days right Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The faw requires that the death certificate be executed attending physician and for use as the burial-transit 10 4 8616 Due to (or as a consequence of): Vascular Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 XNo Live birth 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Tilakaowa 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/2/No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 📉 No Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred . After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TO571 Mai 12 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltonoro. 21231 4/1-3, 20 South Street Kunayama Chester 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 200 L, 15572 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2004 Month Physician 12, Doris Elsie Shellenberger May 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Middle River Baltimore 13230 Sylvan Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | May 12, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 200 F 72 218 28 3129 Vrs 1932 Director Maryland Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or itama 23a or 28e-f shov the Medical Examinar must be notified at 1 ☐Yes 2X No Middle River Directo |Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13230 Sylvan Avenue 21220 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. am 27 is marked other than "netural", or ital 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewi fe Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elsie Otenasek Robert R. Dunaja 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If Itam 27 is any injury or other trau Henry Eugene Shellenberger (Husband) 13230 Sylvan Avenue Baltimore, Md. 21220 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gardens Of Faith Baltimore, Maryland 5/17/2004 \* 4 □ Donation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221 21. Signature of Funeral Service Licensee C 23a. Pagl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastatic 11 months CONCON disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner equires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medicai as the l use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ΡVΙ pe 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 1 Yes 2 No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 ☐ Yes 2X No ို funeral dir 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a Hoapitei 🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier 13th, 2004 address of person who pomple MLN (in . ) impleted cause of death (Hem 23a) (Type, Print)

Still Sand Priser Circle #211, 30. Name and address of person Baltimore, MD 21236 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 4 2004 Registrar A TOTAL SERVICE

DHMH 17 Rev 1/2001

ORIGINAL

04-02967 SAMUEL S SALVO WHM

## Unpend Item 23a 27 PPR MF 6831 5/27/(Vice Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item#1.	State of Ma	ryland	-	artmen rtificate			and M		Reg. N	2 U	04	15573
	Physicia /Medic		1. Decedent's Name (First, Middle, Last Samuel S. Salvo,								2. Date of De Month MAY	D	ay 2004	Year	3. Time of Death  11:50 A <sup>M</sup>
	Examin	_	4a. Facility Name (If not institution, give	street and number)					Location of			4		of Death	
			708 FUSELAGE AVE		//		MII If Under		RIVE If Under		9 Date of Bi	dh		'IMORI	
	Funeral Director		5. Social Security Number 6. Se 213-52-7080  Usual Residence of Decedent	X 7.Age	54	a <i>st birthday)</i> Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Do OCt. 2	19, Yea 2, 19	49	Mary	place (State or Foreign ntry) Land
	aryland show	'n	10a. State 10b. County  Maryland Baltimore		,	Town or Lo								1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	th the M or 28a-f	Funeral Director	10e. Street and Number		111		10f. Zip					-		What Cour	ntry?
	ath wi	rai	708 Fuselage Avenu			2 40		21220		ain? (Cas	sifu Vos or N		S.A.	ce - Americ	ean Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any rightry or othar traumatic avant. It is Medical Evan iter must be notified a sonce.	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4★★ Divorced	12. Was Decedent Examed Forces?  1 ☐ Yes 2 ☑ ★ of If Yes, Give Year or Dates:			was Deced If Yes, spec 1 ☐ Yes	eny Cuba	n, Mexicar Specify:	i, Puerto	cify Yes or No Rican, etc.)	<b>)-</b>		ck, White,	
21215-0036	nin 72 hou in "natura Medicul E	Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)	ication le completed) College (1-4or 5+	.)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	rk done a	<i>lurina</i> mos	t of worki	ng	16b.	Kind of 8	Business/In	dustry
212	ad with	Com	10	- College (1 tot o	<u> </u>	Sheet	Meta	1 Me				_		uctic	on
Maryland	und be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last) Samuel Salvo						Unkn	own	(First, Middle				
Jan	12 sho		19a. Informant's Name/Relationship (7) Roger Dorsey (Pers		١		9				Altimor			_	
e,	1 and Health am 27		20a. Method of Disposition	orat rep.	20b. PI	ace of Dispo	sition (Nan	ne of	1		ate			- City or To	
OL I	ages ent of nt: If il		1 ☐ Burial 2 ☐ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	emetery, crei View C				May ´	13, 200	14 B	alti	more,	Maryalnd
Baltimore,	permit. I Departm Importal any inju		21. Signature of Funeral Sayip Teens	99	_	1	2. Name an	od Addres Br	s of Facili uzdz Laste	inski rn Av	i Funer Jenue	al Ess	Home ex.	P.A. Maryl	and 21221
П			23a. Part1. Enter the disease, or composhock or heart failure. List only of	lications that caused t	the death										Approximate Interval Between Onset and Death
dy.	Physician /Medical Examiner pnuishtansii	i Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. AtheroscI Due to (or as a b. Due to (or as a c. Due to (or as a	consequ	uence of):	liovasc	ular	Diseas	se					
.O. Box 687	death certificate e attending phys d tor use as the	by Physician/Medical	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1  Yes 2 No	d	2 ☐ Fetal	death 3	⊒Ectopic pr ⊒ Other (sp					ĺ		ate of delive	ery Day Year
٥	ign be		Part II. Other significant conditions of	ntributing to death bu	t not resu	ulting in the u	inderlying c	ause give	en in Part I	l. 			use con 2 🗆 No	tribute to t 3 ☐ Prot	he cause of death? Dably 4 Unknown
Vital Records,	The law ate has b page 2 sl	Completed									24a. Wa auto perf		1	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
Vita	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Oth	oc.		(Check only		200		
ō	ding Phys h. Atter this tuneral dir	tion: To	1 X Yes 2 No  27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatier 28a. Date of Injury (Month, Day		ER/Outpatie 28b. Time o Injury		28c. Injury Worl	4 🔲 INI		me 5 ∐ Res 28d. Describe				SCENE
Division	or Attender firer dea Director in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At ho (Specify	ome, farm, st	reet, factor	y, office			28f. Location City or To	(Street own, Sta	and Num ite)	ber or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funaral C completely tilled	edicai (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o iner: On the basis of and manner stat	examinal	wledge, deat tion and/or in	th occurred nvestigation	at the tim , in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause , date a	(s) and m nd place,	anner as s and due t	tated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				290		e number						Day, Year)
			30. Name and address of person who	empleted cause of de	ath (Item	23a) (Type	, Print)		C M E					2004	
			MARIAN	1. KUREU	L		1	11 P	enn S	stree	t, Bal	tim	ore,	Mary.	land 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 4 2004	32. Registra	r's Signa	ture	100								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear RUSSELL STITH 100 PM EDWIN 2004 DE 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 3815 ROLANDVIEW AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Days 15XM 2□ F MD 217-62-2100 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1'SYes 2 □ No MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21215 RO ANDVIEW AVEN 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 ☐ Marned 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER TECHNICIAN 12th, grade FEDERAL COVERNMENT Yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delores STANCIL GORDON STITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4506 TAPSCOTT RD PIKESVILLE MD MILDRED BRICKERS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 05/15/04 WOODLAWN CEMETERY WOODLAWN, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAUGHO C. GREENE FUNERAL SERVICES
5151 BALTIMORE NATIONAL PIKE BALTO MD 2129 21. Signature of Funeral Service License au 23a. Part 1. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or handle adjust. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ste ORDIC Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): 20 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 nce 6 Other (Specify) 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of De 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed and the attending physician signed by peen this certificate has Physician: After death

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter eny injury or other traumatic event, the Medical Examment.

**Physician** 

/Medical **Examiner** 

use as the burial-transit

page 2 should be

the

filled in by

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

other traumatic event, the Medical Examiner must be notified at

the Maryland

death with

Division of Vital Records, P.O. Box 68760, or Attending Director: To the Hospitel or At within 24 hours after C To the Funeral Direct

State Registrar

4000 31. Date filed (Month, Day, Year) MAY 1 4 2004

29b. Signature and title of certifier

6 Could not be determined



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

t 🗆 🚅 📆 🖟 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** mai Juanita Beaulah Simpson 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jarrettsville Harford 3301 Sharon Road If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1□ M 2√ F 82 Yrs 28, 1921 Canada Director 230-20-8218 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland <u>Jarrettsville</u> Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3301 Sharon Road 21084 USA Items 23a Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☑ Divorced White "neturel", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lilly Beaulah (u/k) MacDonald Hershel (u/k) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 3301 Sharon Road, Jarrettsville, Maryland 21084 Daryl Robinson/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition to 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 \* 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Grdns. 5-14-04 Baltimore, Maryland 21. Signature of Fureral Service Licensee 22 Name and Address of Facility Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications by a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Within a da **Physician** ocardia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a por securior of Examiner ician and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 1 No 24a. Was an **2**□1√0 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2₽No 2 ER/Outpatient 3 DOA 1 Inpatient 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Division Hospitel or Attending (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel
within 24 hours a
To the Funerel D 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

MAY 1 4 2004

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32. Registrar's Signat

	•	State of Maryland / Dep	partment of Health and Mertificate of Death		giene Reg. No. 2 0 (	14 15576
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Sarah C. Thomas		2. Date of Dea	Day	Yeer 8:47AM
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	
		NORTH ARUNDEL HOSPITAL		TE		= ARUNDEL
Funeral Director		5. Social Security Number  412-70-0028  6. Sex 1 □ M 2 ☒ F  7. Age (In yrs. last birthda) Yrs.	Months Days Hours Min.	8. Date of Birt (Month, Da 07–24–	n y, Year) 1949	9. Birthplace (State or Foreign Country) Maryland
		Usual Residence of Decedent		07 21	1242	
arylan show	_	10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits 1 ☐ Yes 2 💆 No
the M 28a-f	Directo	Maryland Queen Anne's Milling  10e. Street and Number	gton		10g. Citizen of W	
death with the Maryland ms 23a or 28a-f show rinest be notified at	<u></u>	113 Lime Landing Road	21651		_	USA
15-0036  172 hours after death with the Marylar "natural", or tems 23e or 28e-1 show office! Examples marylar and the modified at	Completed by Funeral		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		- American Indian,
0036 hours after turns, or the	Z.	1 ☐ Never Married 2 XXMarried 1 ☐ Yes 2 XXNo	1 ☐ Yes 2 <b>XX</b> No Specify:	riloari, oto.)	Specify:	
215-0036 bin 72 hours attention in matural, or it	p p	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Dec	edent's Usual Occupation	-	16b. Kind of Bus	
	piet	(Specify only highest grade completed) (Giv life.  Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing	100.71.11.0	
nd 21215- e filed within 72 at Hygiene. I other than "nat vent, the Malie	Com	11th	Homemaker			ome
and be file to be other of other oth	Be	17. Father's Name (First, Middle, Last)  James M. Trott, Sr.	18. Mother's Nam	e (First, Middle, S. M. MCI		a)
Maryland Maryland at 2 should be file th and Mental Hy 27 is marked oth traumatic event	င္		ling Address (Street and Number or Run			State, Zip Code)
imore, Maryl Pages 1 and 2 shoul ment of Health and Me ant. If item 27 is mark ury or other traumati			Lime Landing Rd.		nanowon and	
altimore, mit. Pages 1 at partment of Haa portent: If tiem y Injury or othe 69.		20a Method of Disposition 20b, Place of Disp	position (Name of ematory or other place)	Date		City or Town, State
imor Pages ment of ant: If it		`4 □Donation 5 □ Other (Specify) All Hall		2-04	Birdsvi	
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental trygliene. Important: if tiem 27 is merked other than any Injury or other traumatic event, the pages.			22. Name and Address of Facility Geo 2973 Solomons Islan			
		23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
Physician /Medical	7	Immediate Cause (Final disease or condition resulting in death)	intenction			
Examiner		Due to 1 ras a consequence of):	occlusive de	sease		Yeares
	Jer	S y uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C CCLAZING Q	126626		Tects
ocuted	Examiner	that initiated events				
8760, rate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
687/ tificate lig physi	edicai	d			* * 1	
Box 61 leath certific	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy			of delivery
D. B e death	Physician/Med		Other (specify)		Mon	th Day Year
P.O. hat the dead by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
	ed by			101	res 2□No	3 ☐ Probably 4 ☐ Unknown
aw rec	Completed			24a. Was	an 24b. W	ere autopsy findings available for to completion of cause of
	Com			perfo 1 ☐ Yes	rmed2 de	aath? □ Yes 2□ No
f Vita ysiclan: is certific	Be	25. Was case referred to medical examiner?	26. Place of Deat			
Of Physical direction	2	1 Tes 2 No			dence 6 Othe	
OCH O	tion	27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work? M 1 ☐ Yes 2 ☐ No			
IVISIO r Attendi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (5 City or Tox		r or Rural Route Number,
rs rs			nth occurred at the time of the said of the	and due to the	onunals) and	anar on stated
e Hose 24 ho e Fune etely f	edicai	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, dead of the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	red at the time,	date and place, a	nd due to the cause(s)
To the within To the compl	Me	29b. Signature and fitte of certifier	29c. License number		29d. Date signed	(Month, Day, Year)
0		Kiehard Wilkerson	P17161		May	8,2004
100		30. Name and a ress of person who completed cause of death (Item 23a) (Type	e, Print) with Greene S	to G	3-11-0	1/ wh 21241
Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signary 6	books	)1/\-  _	C. Minny	C MID 51201
Registra		MAY 1 4 2004 Server P	your			

	1	For State Registrar	State of Mary		Departm		ealth and		al Hyg		_	15577
Physician /Medical Examiner		. Decedent's Name (First, Middle, Las Agnes Ver La. Facility Name (If not institution, give	conica	T	imms 4b.	City, Town, or	Location of De	m	ate of Dear	10, 6	Year 2004 nty of Death	3. Time of Death
Funeral Director	4.5	Stella Maris at N Social Security Number 6. S 215-03-5301		yrs. last bir	thday) If U	altimo nder 1 Year nhs Days	If Under 24 F	in. (A	ate of Birth Month, Dey,	Yeer)		nplace (Stete or Foreign untry) Yland
death with the Maryland ms 23e or 28e-f show rmust be notified at		10a. State 10b. County  Maryland Baltime 10b. Street and Number		c. City, Tow	n or Location	. Zip Code			1	0g. Citizen	of What Co	10d. Inside City Limits 1 ☐ Yes 2 No
Furits Print	3	29 Bladen Road  11. Marital Status  1 Never Married 2 Married  37. Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No II Yes, Give Year or Dates:	r in U.S.	13. Was D	21221	spanic Origin? n, Mexican, Pu Specify:	(Specify ) erto Rican	Ţ	J. S.	A. Race - American Am	ncan Indian, s, etc.
21215-003( ed within 72 hours a syliene. ver than "netural", controlled Exam.	Balling	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation		Decedent's (Give kind of life. DO No		ution luring most of t	vorking		16b. Kind of	Business/I	nite ndustry
Maryland 2 Maryland 2  Id 2 should be filed in  It and Mental Hygic  It is marked other it  To Be Co	3	17. Father's Name (First, Middle, Last)  Henry Hammer's 19a. Informant's Name/Relationship (7)		196	. Mailing Add	Iress (Street a	18. Mother's Mary	Tl	neres	a	Regar	
Baltimore, Misoneria Marianore, Misoneria Misoneria Marianore, Misoneria		Paul W. Timms (\$20a. Method of Disposition 12-Burial 2 Cremation 3 \( \) 4 Donation 5 Other (Specify	Removal from State	29 Ob. Place of cemeter	9 Blad Disposition by, crematory	en Roa (Name of or other place	d Esse	Date 5/14	aryla	nd 212 20c. Locatio	221 in - City or 1	Town, State
Baltir Permit. Popartme Importen eny injuri		21. Signature of Funeral Service Licen	aller 5		22. Nam Bruz 1407	Old E	i Facility i Funer astern	Aveni	ome Pi ue Es	A ssex,		Maryland and 21221
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	one cause on each line.  a	onsequence	of):	mode of dying	s such as card	fac or resp	1_17	est,		Approximate Interval Between Onset and Death
760, te be executed sysicien and burial-transit		Sequentially list conditions, if a cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	-								
I Records, P.O. Box 68760, The law requires that the death certificate be example has been signed by the attending physicien bage? should be detached for use as the burian completed by Physician/Medical E.		IF FEMALE: 23b Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	d	Fetal death		ic pregnancy r (specify)		180			Date of delive	very Day Year
ords, P. requires that sen signed by nould be deta	:   ˈ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in	the underly	ng cause give	n in Part I.	2		acco use co		the cause of death?
Vital Record sician: The law requir certificate has been s irector, page 2 should be Completed	) :	25. Was case relerred to medical					26. Place of D	1		ned2 No	prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
<u> </u>		examiner?	Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye		tpatient 3[ ime of njury	DOA Othe	r: 4 🗆 Nursing	Home 5	Reside	-	Other (Speci	rigedin
- is is is o		3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	(pecify)		ctory, office		C	ity or Town	, State)		al Route Number,
To the Hosp within 24 hou To the Fune completely fill Medical		(Check only one)  2 Medical Examone)  29b. Signature and title of certifier	ysician: To the best of miner: On the basis of exa and manner stated.	mination and	d/or investiga	tion, in my op	inion, death oc	curred at t	he time, da	ite and plac	e, and due t	o the cause(s)  Day, Year)
6		30. Name and address of person who	completed cause of death	(Item 23a) (	Type, Print)	DHI	1 0.	R	17,	5	11/2	207
State Registrar		31. Date liled (Month, Day, Year)  MAY 1 4 200	Se Devo	Signature	Gowelle	FILL	L TL.	100	ci Hy	nore		202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MFND ITEM #2819b PER PHY G831 5/25/Que difficate of Death Reg. No. 2. Date of Death WAY 08 2004 1. Decedent's Name (First, Middle, Last) :03P M Sara **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number Examiner LINWOOD BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) (ALOLINA 5. Social Security Number 249-34-2200 8. Date of Birth (Month, Pay, Year) 7. Age (In vrs. last birthday) **Funeral** Months 1□M 20F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow Examiner must be notified at 1 Yes 2 No MD SAUTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 1409 LININOOD Items 23a Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc Specify: BLACK 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired).

HECKER 16h Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) DRY CLEANERS permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "ray injury or other traumatic event, the Med any injury or other traumatic event, the Med BORGs. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GMMA ျှ 19b 1209 LFM CFP SAVE Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SALTO, MO 21213 OLINE DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State RE CEMETERY 5.14.04 BACTIMORE, MARYLAND 22. Name and Address of Facility VAUGHTN C. SKEENE FUNERAL HOME BACTIMORE CEMETERY \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PORK ROAD BACTI MORE, MARYLAND 21212 July 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) an Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by eq 2 200 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 2 No 1 Yes 2 0 No of Vital 25. Was case referred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Zn sidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28d. escribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the f within 24 hours after deatl

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 48 2 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUD 3120 Desau 32. Registrar's Signature 31. Date Ned (Month, Day, Year) State

**ORIGINAL** 

Registrar

fations known as Harold Adams

The taw requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physician:

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 200 4 3:50 PM **Physician** arul Man /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Baltimore City of 8. Date of Birth Almonth, Day, Year ADCU 22, 1957 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Qountry) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. 1 M 2□F Months Days Hours 214-64-856 Director-Ira Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show if item 27 is marked other than "natural", or itema 23a or 28a-f sho or other traumetic event, the Nexton Exact at must be notified at 1 Yes 2 No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 2 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: ð 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 2 nayman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other traumatic event 2008. 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 21216 TD. ohir 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12004 1 Burial 2 ☐ Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) arme 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral 1. Hom L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days **Physician** a Heratic inciphaiopathy /Medical Due to (or as a consequence of): Examiner years Liver comar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner igned by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by alcoholism chronic 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Heparins certificate has 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier 11, 2004 RES-000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Since Hospital of Baltimore Javillo MO Jason 5. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

**ORIGINAL** 

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	1-	For State Registrar	3	iale oi ivi	arylari			e of Dea		•	Gleile Reg. No	2001	+ 15	5580
	_	Decedent's Name (First, Midd	(e, Last)							2. Date of De. Month		v 11- v		ne of Death
Physician /Medical		FLORENCE		Ε.	AD	COCK				May	ا أ	3th, 20		15 AM
Examiner	4a.	Facility Name (If not institution		12.	11	- (11.)	4b. City,	Town, or Loca			1	. County of De	18	Pai
			nm		468	7514	C7	-100		nie		rung		ma e)
Funeral Director		ocial Security Number 18-01-4837	6. Sex 1 ☐ M		ge (In yrs. I 83	ast birthday) Yrs.	Months		nder 24 Hrs. urs Min.	8. Date of Bird (Month, Da Feb. 03	y, Year)	9. B	irthplace <i>(St</i> t <i>Country)</i> [arv1a:	ate or Foreign
9	Usu	al Residence of Decedent			1.0 0					160.03	1 7 2	Z_I		
Aarylau I ehow		Md . Anne		el Co.		r, Town or Lo asadei								de City Limits Yes 2 \ No
r 28a-	10e	. Street and Number				45446.		o Code			10g. Cit	tizen of What C	Country?	
nore, Maryland 21215-0036 upos 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Medical Example motified at To Be Completed by Funeral Director	2	7626 Bensway	7				2	21122				U.S.A	•	
r dee	11.	Marital Status		Was Decedent Armed Forces	7	S. 13.	Was Dece If Yes, spe	dent of Hispani cify Cuban, Me	ic Origin? (Spe exican, Puerto	cify Yes or No Rican, etc.)	•	14. Race - An Black, Wh		n,
rs afte		1 ☐ Never Married 2 ☐ Ma 3 🌠 Widowed 4 ☐ Divorce	ried	I □ Yes 2 ₩ If Yes, Give X Year or Dates:	No		1 ☐ Yes		ecity:			Specify: wh	ite	
1 21215-0036 led within 72 hours at ygiene. her then 'natural', or it, the Medical Exam.		15. Decede	nt's Education	on		16a. Dece	dent's Usu	al Occupation			16b. K	ind of Busines		
215	E E	(Specify only higher lementary/Secondary (0-12)		College (1-4or	5+)	life.	DO NOT u	ork done during ise retired)	most of worki	ng				
Lt. English	5	12	( ) - t)	00		House	ewife					ome Own	er	
Maryland 2121 d 2 should be filed within d 2 should be filed within the and Menial Hygiene. To is marked other then traumatic event, Illam To Be Comp	Ď.	Father's Name (First, Middle Sigmond	J.	D	eckli	20				(First, Middle,	Maiden	,		
ryla hould d Men marke marke		a. Informant's Name/Relation			eckii		ng Addres		Jennie	I Route Numbe	ar City o	Burge		
Ma nd 2 s uith an 27 is r trau		ames B. Adcoc		(Son)						in, Md.			Zip Oode)	
of Head	20a	. Method of Disposition			20b. PI	lace of Dispo emetery, crea				ate		ocation - City o	r Town, Stat	Θ.
altimo		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	3 ∐Remo Specify)	oval from State				em. Pk.	05/19	/2004	G1e	n Burni	ie, Md	
Baltimore, permit. Pages 1 a Department of Hea Important: If tem emportant: on the	21.	Signature of Funeral Service	Licensee)	Prin	nell	A) 2:	2. Name ar MCC	ad Address of Fully Po	acility Olyniak	Funera	a1 H	ome P.A	A. 2112	2
	23	a. Part1. Enter the disease, of shock, or heart failure. Lis	r complication	ons that cause	d the death	. Do not en	ter the mod	de of dying, suc	ch as cardiac o	r respiratory ar	rest,	na, mo.	Approx	
Physician	dis	mediate Cause (Final ease or condition		Y	MR	tas	Ta	fre (	Color	n Co	in	ch	Onset	and Death
/Medical Examiner	res	sulting in death)		Due to (or as	a consequ	uence of):								
8	Se	quentially list conditions,	b	Due to (or as	a consedu	ieuce ob								
m and rial-transit	Cal	quential y list conditions, ny, leading to immediate ise. Enter Underlying use (Disease or injury t initiated events	<b>{</b>	(0.00										
60, tolar and burial-transit	i res	ulting in death) Last	С	Due to (or as	a consequ	rence of):	-			· · · · · · · · ·				
Z Z Z Z Z			d											
Box 687 leath certificate attending phy Ifor use as the	F IF	FEMALE:												
Box sath cert attendin for use	231	b. Was decedent pregnant in the past 12 months?		If yes, outcome 1□Live birth	2 Fetal	death 3	Ectopic p					23d. Date of do Month	elivery Day	Year
al Records, P.O. Box 68  The law requires that the death certificate has been signed by the attending phy page 2 should be detached for use as the Completed by Physician/Med	331	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant a 9□Unknown	it tiltne of de	adin of	Other (sp	э <del>в</del> спу)						
s that s that med b e deta	Par	t II. Other significant condit	ons contrib	uting to death I	out not resu	ılting in the u	nderlying o	ause given in F	Part I.	23e. Did to	obacco i	use contribute	to the cause	of death?
Vital Records, sician: The law requires to cartificate has been signe rector, page 2 should be e. Be Completed by	ğ	congl	HV	4 17	16 6~W	1	10	milin	<u> </u>	101	/es 2	No 3□F	robably 4	Unknown
ecc law ra law ra as be as be 2 sh	<u> </u>	J.								24a. Was autop	SV	24b. Were a	autopsy findi	ngs available
Vital Recsician: The law certificate has t irector, page 2 s	5									perfo	rmed? 2 No	death?		
/its	25.	Was case referred to medica examiner?	ll Hosp	ital:					Place of Death	(Check only o	ne)			
- S S D	27.	1 Yes 2 No		8a. Date of Inju		ER/Outpatier 28b. Time o		OA Other: 4[ 28c. Injury at		ne 5 🗆 Resid 28d. Describe f			ecify)	
on ding th.: After fune	2	1 Natural 5 ☐ Pendi		(Month, Da	y Year)	Injury	м	Work? 1 ☐ Yes	_	LOG. DOSCHDO	iow silui	y occurred		
Division of to attending Physical death. Director: After this in by the trneral directification: To ertification: To	2	3 Suicide 6 Could 4 Homicide deter	not be	8e. Place of In	jury - At ho	me, farm, st	reet, factor			28f. Location (S	Street an	nd Number or F	Rural Route	Number,
Division of the or Attending P is after death. el Director: Attented in by the funera		4   Homicide		building, e	tc. (Specify	") 			7	City or Tou	vn, State	o <i>)</i>		
Division or To the Hospitel or Attending Physibin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		a. Certifier 1 Certifyi (Check only 2 Medica	ng Physicie Exeminer:	On the basis of and manner st	of examinat	wledge, deat ion and/or in	h occurred vestigation	at the time, dat , in my opinion,	te and place, a , death occurre	and due to the o	cause(s) date and	and manner a place, and du	is stated. le to the cau	se(s)
Fo the somple	291	o. Signature and title of certific	er S				29	c. License num	ber		29d. Da	te signed (Mor	ith, Day, Yea	ir)
		1	++	= 7	m	1)	1)	4800	06	V	Ma	7 13	古。	2004
10	30.	Name and address of person	who compl	eted cause of	death (Item	23а) (Туре,	Print)	( -0)	1 /	/	1.	77		1
IV	14	Date filed (Month, Day, Year	0171	32 Posie	r's Signat	SV	H	syst	al b	7-1 C	ラー	かりい	~ m1 4	my
State Registrar		MAY	172	104 D	Jaga de	Mary To	La	1 -						

Adovek

Florance

		1 - For Amend Item 24	<sub>a</sub> State of Manden	95/95/04/1999 Certifica	nt of Health and te of Death		i. No. 0 0 L	15581
Physic		1. Decedent's Name (First, Middle, Last,		AVERE	TTEE	2. Date of Death	2004 Year	3. Time of Death 10:00 PM
/Med Exami		4a. Facility Name (If not institution, give GOOD SAMARITAN HO	street and number)	4b. City	, Town, or Location of Dea		4c. County of Death	
Funera Director		213.20 2003	7. Age (In yrs. )	Yrs. If Under Months	or 1 Year If Under 24 Hrs Days Hours Min		9. Birthp Coun 1940 NORT	place (State or Foreign http:// CALOUNA
with the Maryland e or 28a-f show	tor	Usual Residence of Decedent  10a. State  10b. County		y, Town or Location AUTIMOK	'E		1	0d. Inside City Limits 1 1 Yes 2 □ No
with the 3e or 28a	Direc	10e. Street and Number	DE DR. APT		21234	10g	g. Citizen of What Cour U.S.A	
-UU35 hours after death with the Maryla tural; or tems 23e or 28a-f shov at Exanirer must be nutified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eyer in U. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	S 13 Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: BU	
47215-0036 d within 72 hours af piene r then "netural; or read the second	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	cation le completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	rork done during most of w use retired)	orking	SECUR	·
9 0 0 0	To Be Col	17 Father's Name (First, Middle, Last)	n AVERETT		18. Mother's Na	ame (First, Middle, Ma		
Maryland nd 2 should be file lith and Mental Hy 27 Is marked oth rtreumatic even	1	19a. Informant's Name/Relationship (7) MARY AVELETTE		40h Mailine Adden	ss (Street and Number or F EU BLIDGE	DR. APT. C	City or Town, State, Zip	et. Mo 2123
of Hear		20a. Method of Disposition  1 Burial 2 PCremation 3 1  4 Donation 5 Other (Specify,	20b. F	Place of Disposition (Nemetery, crematory of	ame of other place)	Date 20	Oc. Location - City or To	own, State MARUIANO
Baltimo permit, Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	688	22. Name	YORK ROAD	WAHN C. G	REENE FU	NERAL HIME
icate be executed E WINTER DISCOUNTED TO THE Purial transit e big.		23a. Part1. Enter the disease, or compshock, or heart failure. List only compensation of the compensation	ne cause on each line.	rotic Card	iovascular D			Interval Between Onset and Death
Box 6 ath certif	Physician/Med!	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1□Live birth 2□Fete 4□Pregnant at time of c	al death 3 Ectopic			23d. Date of delive	rery Day Year
ds, P.O. I ires that the de signed by the a d be detached f	ğ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	g cause given in Part I.		acco use contribute to t	
I Records, The law requires t ate has been signe page 2 should be o	Completed					24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
Vita siclen: certific irector,	o Be C	25. Was case referred to medical examiner?  XXYes 2 \( \times \) No	Hospital: 1 ☐ Inpatient 2 🛭	ER/Outpatient 3□	Other	eath (Check only one	nce 6 Other (Specia	ify)
ding After fune	<u>}-</u>		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how		,
is gig a	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci	ity)		City or Town,		
Hospitel 24 hours a Funerel l	Medical		ysician: To the best of my kn hiner: On the basis of examin- and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the car curred at the time, dat	use(s) and manner as s te and place, and due t	stated. to the cause(s)
To the within 2. To the complet	Med	29b. Signature and title of certifier  Theology U.	Ve down		O C M E	29	od. Date signed (Month, MAY 7, 200	
		30. Name and address of person who Theodore King M.		m 23a) (Type, Print) $oldsymbol{1}$	l Penn Stree	et, Baltimo	ore, Maryla	and 21201
Pogi	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	sature Spi	reket			

		4	Plea  1 - For Stote Registrar	se Type or Pri State of M		Depart		lealth and N			Legible.	4 15582
	/sicia ledica	n	1. Decedent's Name (First, Middle	Robert	Wilson	Bur	ns		2. Date of De Month	eath Day	2004	3. Time of Death
à.	amine		4a. Facility Name (If not institution 1010 North Man	-			Ess					ore Co.
Fune Direc			5. Social Security Number 212-48-3726	1₩ 2□F	ge (In yrs. last bii 54		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ey, Year)		hplace (State or Foreign untry) ryland
Maryland f show	IN DAI		Usual Residence of Decedent  10a. State 10b. County	31.	10c. City, Tow	n or Locati		Essex				10d. Inside City Limits 1 ☐ Yes 2 ☑No
with the	II De uoi	al Director	Maryland Ba 10e. Street and Number 1010 North Man	altimore rlyn Avenue			10f. Zip Code	21221			zen of What Co ited St	
ie, with yiell of I.E. 12-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "netural", or Iteme 23s or 28s-f show	Naminar mu	by Fur	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☑ Divorced	If Yes, Give	?		Decedent of Hiss, specify Cubi	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		14. Race - Ame Black, White Specify:	
hin 72 ho	Medical	Completed		t's Education st grade completed)  College (1-4or		(Give kind	's Usual Occup d of work done NOT use retired	during most of world	king	16b. Kii	nd of Business/	Industry
2 should be filed with and Mental Hygiene.	svent, the	Be	12 Years 17. Father's Name (First, Middle,				Manage:	18. Mother's Nam		. Maiden	dio Sha Sumame)	ck
and 2 should ealth and Men	r traumatic	၀	Homer Burns  19a. Informant's Name/Relations  Ida Burns	hip <i>(Type, Print)</i> / Mother	198	_		and Number or Ru.		per, City or	Town, State, 2 Maryla	
Darkinione, iv permit. Pages 1 and Department of Health Important: If item 27	ary or other		20a. Method of Disposition  **Danation 5 Other (S		•	ry, cremato	on (Name of pary or other place)  Je Mem.	ce)	Date 17/2004		cation - City or	Town, Stete Mary1and
permit. Departr	eny injection		21. Signature of Buneral Service	2		Duda 792	2 Wise	Funeral H Ave. Du	ndalk,	Maryl	alk, In	L222
Pnysic /Med Exami	ical		23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	a. A - Due to (or as	ine.	tic C		ascular				Approximate Interval Between Onset and Death  / G year S
cate be executed only sicien and	the burial-transit	edicai Examiner	Sequentially list conditions, 1 sry lection; to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence							
Physician: The law requires that the death certificate be at this certificate has been signed by the attending physicien	ched for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		topic pregnancy her (specify)	у		2	23d. Date of deli Month	ivery Day Year
requires that I	pe det	by P	Part II. Other significant conditi	ons contributing to death t	but not resulting	in the unde	rlying cause giv	ven in Part I.			se contribute to	the cause of death?
in: The law requiricate has been	, page 2 should	Completed							24a. Was auto peri 1 🗆 Yes		24b. Were au prior to death?	topsy findings available completion of cause of
Physician: The this certificate	il director	To Be	25. Was case referred to medica examiner?  1 Yes 2 □ No	Hospital: 1 ☐ Inpati		-	3□ DOA Oth	4   Nursing H	ome 5 Res	idence 6	S □Other (Spec	cify)
II ga	by the funeral director, page	ertification;	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	gation		Time of Injury	M 1 □	ryat rk? Yes 2 ∐No	28d. Describe	how injur	y occurred	
To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After	led in by t	Certific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Place of In	iury · At home, fa tc. (Specify)	arm, street,	factory, office			(Street and own, State)		iral Route Number,
he Hospi in 24 hou he Funel	completely filled in	edical	29a. Certifier 1 Certifyin (Check only one) Medical	ng Physician: To the best Examiner: On the basis of and manner s	of examination ar	e, death od nd/or invest	curred at the til	me, date and place, opinion, death occur	and due to the red at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To t with To t	com	2	29b. Signature and trie of certific	cad am	utv		D 18				signed (Monti	**
		4	39: Name and address of person Philip Mili	who completed cause of tello, MD	death (Item 23a)	(Type, Prin	1:4CT.	3667 Luthen	sille.r	lary	and z	1093
Re	Stat gistra	571	31. Date filed (Month, Day, Year,	32. Regist	rar's Signature	Som	ero .				-	

			1- State of Maryla		artment of H		-	ene g. No. 2001	15583
			Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physicia		Charlotte D. Brice				May 12,	Day Year	9:45 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		,y	4c. County of De	
			College Manor			nerville		Balt	imore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		213-28-1948	79 <sup>Yrs.</sup>			Apr. 3,	1925	Maryland
	land	1	Usual Residence of Decedent           10a. State         10b. County         10c. County	ity, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	jo	Md. Baltimore		Tows	<b></b>			1 ☐ Yes 2 🔀 No
	r 28a	Director	Md. Baltimore  10e. Street and Number		10f. Zip Code	JI 1	10	g. Citizen of What C	Country?
	h with		1117 Gypsy Lane West		21	286		USA	
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	nerican Indian, lite, etc.
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be indiffed at	d be	3 ⊠ Widowed 4 □ Divorced Year or Dates:	16a Decer	dent's Usual Occupa	ation	1	6b. Kind of Busines	White
15	in 72 n "na	Completed	(Specify only highest grade completed)	(Give	kind of work done d DO NOT use retired,	lurina most of work	ing		
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Hom	nemaker			Own Ho	me
p	al Hy I othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Madical Examinst must be inclifted at once.	To	Thomas M. Duer, Sr.				rlotte W		
Nar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Type, Print)	1:	-		_	City or Town, State,	
e,	1 and Healtl em 2 ther 1		Mrs. Peggy Duer/Niece  20a. Method of Disposition 20b.		Gypsy Lar sition (Name of natory or other place			Maryland Oc. Location - City o	
Jon L	ages nf of t: # it		No Burial 2 Cremation 3 Chemoval from State			1			
₫	ritme crten injury		21. Signature of Funeral Service Licensee,	. Marga	RET LEMET  . Name and Addres	Sery 5/1	ck Tower	nnapolis,	Maryiano Home, Inc.
B	Deperminant in post in		muchael / Dust	//	1050 York	k Road T	owson. M	arvland 2	
			23a. Part1. Enter the disease, or complications that saused the desphock, or heart failure. List only one cause on such line.	ath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Stol	10,06	011100	effer	SIM	Onset and Death
	/Medical Examiner		resulting in death)  Du to (or as a conse	quence of):	, 9				400 00
	Laminer	_	if any leading to immediate  Due to (or as a const		ko ska sl	5			10 months
	ted	nine	cause. Enter Underlying Cause (Disease or injury	ntm/h	af KA	a hope	<4		1711000
7	execunand and ial-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):	01100	e preu	-01		1xyears
8760	death certificate be executed e attending physician and nd for use as the burial-transit	dicai	d						
9	r certifica Inding ph use as th	Med	IF FEMALE:						
Box	attending for use a	by Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fe	tal déath 3 [	Ectopic pregnancy			23d. Date of d	elivery Day Year
o.	the deg y the a	ysic	1 Yes 2 No 9 Unknown	death 5∟	Other (specify)				,
Δ.	res that fhe de igned by the be detached	/ Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause give	en in Part J.	23e. Did toba	acco use contribute	to the cause of death?
Vital Records,	es pe pe	d b	Chronic, obstruction	e pu	monara	y discas	¥ 1 □ Yes	s 2000 3 1 1	Probably 4 Unknown
00	s been s	Completed	Cerebrovoscub r disease	with	history	OF	24a. Was an		autopsy findings available
Be	The law	mo	multiple PUASIS	Looks	< \		autopsy perform	jed? death?	completion of cause of
ital		Bec	25. Was case referred to medical	17 OKK	)	26. Place of Deat	h (Check only one		
	Physician: this certific ral director.	ToE	examiner?  1   Yes   2   No   Hospital: 1   Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Othe	or. Nursing Ho	me 5 Resider	nce 6 Other (Sp	ecify)
n o	ng Pl		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	Work	(?	28d. Describe how	w injury occurred	
sio	Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not be	hama fara at		fes 2□No	28f Location (Cto	ant and Number or I	Rural Route Number,
Division of	or Attendate death Tilector: /	Certification:	4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	nome, tarm, str cify)	eet, ractory, onice		City or Town,		nural moute ivulliber,
_	Hospital or 24 hours afte Funerel Dir tely filled in I		29a. Certifier Certifying Physician: To the best of my ki	nowledge, deat	h occurred at the tim	e, date and place,	and due to the car	use(s) and manner a	as stated.
	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	(Check only one)  2 Medical Examiner: On the basis of examiner stated.	nation and/or in	vestigation, in my op	pinion, death occur	red at the time, da	te and place, and du	ue to the cause(s)
	To the To the comple	5	29b. Signature and title of certifier	/	29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
)			Alla Stoog In	D, PA	DOC	30717	(	25/13/	2004
	15		30. Name and address of person who completed cause of death (Ite	em 23a) (Type.	Charles	516	1	Balter	nore MD
		••	31. Date filed (Month, Day, Year) 32. Registrar's Sign	TO IV	Charles	21001	12 Das	1 2	1304
	Sta Registi		MAY 1 7 2004	Buce - 1	4 April				
			1	Charles and	A STATE OF THE PARTY OF THE PAR				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Ruthie H. Bass 4:10 PM 3 2004 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Rose Hospi SQUARE IMORE dA /e If Under 24 Hrs. Hours Min. 8. Date of Birth Month, Day, Year) 02/17/1920 5. Social Security Number (In yrs! Birthplece (State or Foreign Country) **Funeral** Deys Months 1□ M 2Q F 244-36-7943 84 Director North Carolina Usuel Residence of Decedent permit. Pages I and 2 should be filed within 72 hours effer death with the Marylen. Department of Health and Mentel Hygiene. Important: if Item 27 is merked other than "natural" any injury or other traumetic average. 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits MD Harford 1 ☐ Yes 2 No Funeral Director Joppa 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 K Cider Press Court 21085 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) City of Baltimore Clerk Accounting 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther Howell Hattie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Folster Knoll Drive, Joppa, MD 21085 Michael D. Bass - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Garrison Forest 05/19/04 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Aaron Brown Leonard J. Ruck Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Pert1. Enter the disease, or concentrations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Attending Physician: The law requires that the death certificate be ex-Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? his certificate has I if director, pege 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after deeth.

To the Funeral Director: A completely filled in by the ft investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certified 29d. Date signed (Month, Dey, Year)

Registrar DHMH 16 Rev 6/95

State

9000 FRANKlin SqUARE DR. BAITIMORE Md 21237

(Item 23e) (Type, Print)

32. Registrar's Signature

30. Name and eddress of person who completed cause of deep

2804

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KAM

31. Date filed (Month, Day, Yo

State of Maryland / Department of Health and Mental Hygiene 2 11 11 4 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5 **Physician** 30 9 Brown 04Shirley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5-4-55 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Baltimore, Md 1□ M **3**(□ F 49 Yrs 214-64-5128 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 28a-f show in than "natural", or fleme 23s or 28s-f show the Medical Examinar must be multified at 1 X Yes 2 ☐ No **Funeral Director** Md. N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21218 USA 1623 Argonne Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after 1 Never Married Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Of Md. Clerk Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Beatrice ပ Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 Argonne Dr. Baltimore, Maryland 21218 Emanuel Brown Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-14-04 Crownsville, Md. Crownsville VA. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility
Estep Brothers Funeral
1300 Eutaw Place, Baltim
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 01 S-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 🗌 Yes 2 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Certification: To 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funarel Director: A completely filled in by the fu investigation 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and tills of certifier who completed cause of death (Item 23a) (Type, Print) EINE V ريا 31. Date filed (Month, Day, Year) 32. Registra Signature State MAY 1 7 2004 > Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician May Brewer 2004 1800 Rosanna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) March 11,1935 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛣 F 69 275-48-2755 Italy Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location in than "natural", or items 23a or 28a-f ehow the Medical Examinar coust be notified at 1 ☐ Yes 2 😿 No Director Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 839 Clifton Avenue USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. e filed within 72 hours after if Hygiene. other then "natural", or ite 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If Item 27 is marked othi eny injury or other traumatic event Be Alberto Falcinelli Pina Scarpctella 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Brewer (Son) 1362 Linden Avenue, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tXXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Anne's Cemetery 5/18/2004 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service 23a. Part F. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death adder Cancer Immediate Cause (Final disease or condition **Physician** 2/2 4105 disease or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine and burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy performed? certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient ů 2 X ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funerel Director: After to Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis, Wed, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

		for State	State of Marylar	nd / Depa		lealth and	Mental Hygie	_	15507
		Registrar     Decedent's Name (First, Middle, Last)		06	runcate or i	Death	2. Date of Death		3. Time of Death
Physic /Med		DEBORAH LEE	BOXLEY		,		MAMYnth 10,		1:55 P M
Exami		4a. Facility Name (If not institution, give			,	r Location of Deat	h	4c. County of Death	
		PRINCE GEORGE  5. Social Security Number 6. Securit		last hirthday)	CHEVERI If Under 1 Year		8. Date of Birth	PRINCE 9. Birth	place (State or Foreign
Funeral Director		Usual Residence of Decedent	]м 2 <b>X</b> F 72	Yrs.	Months Days	Hours Min.		931 Nort	h <sup>try)</sup> Carolina
Manyland f ahow	or	10a. State 10b. County MD • PRINCE (		ty, Town or Lo					10d. Inside City Limits
ith the M or 28a-f	rect	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
h with	ai D	5999 EMERSON I			21701		U	.S. OF A	•
I E, IVICILIY STATION AT INTENDED.  1 and 2 should be filed within 72 hours after death with the Maryland Hygiene 1 Health and Mental Hygiene Thauturel', or Items 23a or 28a-1 ahow tiem 27 is marked other than "naturel", or Items 23a or 28a-1 ahow other traumatic event, the Medical Examiner must be inclined at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed	12. Was Decedent Ever in U Armed Forces 1 ☐ Yes 2 W No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: B	
nature	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a Dece	edent's Usual Occup a kind of work done DO NOT use retired	ation during most of wo	rking	6b. Kind of Business/l	ndustry
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Id be filed ental Hygi ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) JIMMY LEE	INID TUANO				me (First, Middle, Ma A STREET	iden Sumame)	
VICILY 12 shou h and M 7 is mar traumat	-	19a. Informant's Name/Relationship (7) SHELIA MAYFIELI			•			City or Town, State, Z	
T and Healt Healt Sem 2		20a. Method of Disposition	20b.	Place of Disp	osition (Name of		Date 20	c. Location - City or	Town, State
Page: ment o tant: If		1 Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)			n'°cemett			NSDOWNE,	
DOIL permit. Departi Import		21. Signature of Puneral Service Licens	WIS T. GWY					HOME 212	
		23a. Part1. Enfer the disease, or comp shock, or heart failure. List only o	ications that caused the dea	th. Do not en	517 PARI	HEIGH ng, such as cardia	TS AVENU c or respiratory arres	E BALTO	Approximate
01		Immediate Cause (Final	ne cause of each line.	1		0020	+		Interval Between Onset and Death
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Examine	\$	Sequentially list conditions,	. Septic	em	ia.		*		3 week
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BOX 68 sath certificat attending phy for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet		□Ectopic pregnanc			23d. Date of deli	
the death y the atte	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of		Other (specify)			Month	Day Year
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VITAI MECONA: ician: The law require certificate has been si-	Completed	Mel cere	lucrance	lan	acci	dent	24a. Was an autopsy	prior to d	topsy findings available completion of cause of
	Cou						performe		2 No
VITA vician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	TER/Outpatie	2 70A Ott	or.	ath (Check only one)		
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DIVISION I or Attending after death. Director: Afte	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	nome farm s		Yes 2 □No	28f. Location (Stre	et and Number or Ru	ral Route Number.
Ltal or A rs atter al Directed in by	Certification;	4 Homicide determined	building, etc. (Spec				City or Town,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 6 Himor 7. Age (In yrs. last birthday)
Yrs. Funeral Social Security Number 6. Sex Birthplace (State or Foreig Days Hours 1□M 2X(F Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland 1 XYes 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or T 20b. Place of Disposition (Name of cemetery, crematory or other place) Health tem 27 Important: If Item 2 any injury or other once. Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Son 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hong Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cancer olon Ucacs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physicien and use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 9☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Na. Pt CE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funeral ( To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Baltimore mo 21204 Adran Charles und 6601 24 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 1 7 2004

			1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H tificate of I	ealth and Death	d Mental	Hygier Reg. i	ne2004	15589
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Month		Day Yeer	3. Time of Death
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	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
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	r 28a	Director	10e. Street and Number		VI U III	10f. Zip Code			10g.	Citizen of What Cour	ntry?
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Maryland 21215-0036	"natural", o	by	3X Widowed 4 □ Divorced  15. Decedent's Edu	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo dent's Usual Occupa	Specify:		16h	Specify: B1:	
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	/Medical Examiner		resulting in death)	Due to (or as a consequence	ence of):	110 . Th	2-02 m. h	5516			
		e.	Sequentially list conditions if any, leading to immediate	Due to (or as a conseque		U.S.IV. IV	77070-20				
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. Box	death certif e attending ed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 ☐ Live birth 2 ☐ Fetal ( 4 ☐ Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)		·	_	Month Month	Day Year
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Division	if or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location City of	on (Street Town, St	and Number or Rura ate)	l Route Number,
_	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by It	edical Ce	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati	rledge, death	occurred at the tim	e, date and pla	ice, and due to	the cause	(s) and manner as st	ated.
	thin 24 the F	Medi	29b. Signature and title of certifier	and manner stated.	2- 111	29c. License				Date signed (Month, I	``
	T Will		_	in iD			M.E.			10,2004	,,,
	~1		30. Name and address of person who co		23a) (Type.				1-14-2 T	10,2004	
				m. 7			Street	, Balti	more,	Maryland	21201
	Sta Regista		31. Date filed (Month, Day, Year)  MAY 1 7 2004	32. Registrar's Signatu	ILO (						

State of Maryland / Department of Health and Mental Hygiene? 15590 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 13, 2004 **Physician** 5:50 A M COHEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE HEBREW HOME OF GREATER WASHINGTON Hours Min. 8. Date of Birth FEB. 12, 1911 9. Birthplace (State or Foreign Country) ENGLAND 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days Months 1 □ M 2 🙀 F 93 101-38-6179 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Neulical Evan. In many once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 🙀 No ROCKVILLE MONTGOMERY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 6121 MONTROSE ROAD Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify. 3 

Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS LADIES WEAR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SINGER LIPSCHITZ ANNIE RUBEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10618 KENILWORTH AVENUE #101 - BETHESDA, MD 20814 ROBERTA JASKULSKI / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State NEW MONTEFIORE CEM. 5/14/2004 PINELAWN, NY \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral Se 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician COLON disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and you are greatly grea Due to for as a considuence of Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 mon 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ Mollitus 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 No certificate Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Cther: 4 Z Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 P No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of After the funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 55258 MAY 13, 2004 m.D 30. Name and address person who completed cause of death (Item 23a) (Type, Print) MUEVILLE MAYLAND 6121 MINTROJE B WIKS

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

7 2004

32. Registrar's Signature

			For	State of M	Maryland / [	Department of H		lental Hygier	e 2001	15501
		_1	For State Registrar			Certificate of	Death	Reg. N	lo.	10001
	Physicia		Decedent's Name (First, Middle		11.			n	ay Year	3. Time of Death
	/Medic	al	CIITTOID .	SIDKEY	COUTTER	4b City Tours	or Location of Death	may 3	Ic. County of Death	1/
	Examin	er '	4a. Facility Name (If not institution	, give street and number	me	1	tonsvill	_	12	incre
	E		5. Social Security Number	6. Sex 7. 1	Age (In yrs. last bii	rthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		217-12-7950	1 <b>□</b> M 2□F	79	Yrs. Months Days	Hours Min.	May 19, 1	934 MM	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	P .	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Location		/ /	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	anylan			Hand		TOUSUIT	4			1 ☐ Yes 2 No
	the M	Director	10e. Street and Number	HMORE	(. )	10f. Zip Code	σ	10g. (	Citizen of What Cou	intry?
	with		O	PANES LI	m c		207		USA	
	death	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White	
9	or ita	Fur	1 Never Married 2 Marr	ied 1 Yes 2 [		1 Yes 2 No		ritoari, oto.)	Specify:	1
21215-0036	72 hours after death with the Maryland Insturati, or Itams 23a or 28a-f ahow dies Examinatin vast be notified at	d by	3 Widowed 4 Divorced	Year or Dates				1.00	15	140/6
5-	"natu	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	168	<ol> <li>Decedent's Usual Occup (Give kind of work done life. DO NOT use retire</li> </ol>	pation during most of work id)	ing 160.	Kind of Business/li	idustry
12	within ene. than *	dwc	Elementary/Secondary (0-12)	College (1-4c	or 5+)	Tunetor	Dri		MUSHIP	TRADE
	filed Hygid othar ant, I	a)	17. Father's Name (First, Middle,	Last)	11		18. Mother's Name	e (First, Middle, Maid		
<u>a</u>	Jid be Aental rked c tic ava	ToB	Sioney Er	SKINE CO	ulter		Floren	ce Hou	612	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. It it health and Mental Hygiene. If itam 27 is marked other than "natural," or itams 23a or 28a-f show it it itam 27 is marked other than "natural," or itams 21 is marked other than "natural".		19a. Informant's Name/Relations	hip (Type, Print)	191	b. Mailing Address (Street	2	al Route Number, Cit	y or Town, State, Zi	p Code)
-	1 and 1 Health am 27 other tr		MAYIE WUST	Up / 6511.	20h Place	20/ St. Ag	pes Lon	Mate 1 200	Location - City or T	d 2/20)
Baltimore	ges 1 it of H if ita or ot		20a. Method of Disposition  Disposition  2 □ Cremation		.(9	of Disposition (Name of ery, crematory or other pla	(0)	10/04		m. I
ij	t. Pa rtmen rtant: njury		<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>		Cour	22 Name and Addres	ass of Facility	ten Cho	Normi	L'ALLANGE
Bal	permit. Pages Department of I Important: If its any injury or of		July H	6		5240 RE	nel dil	1 Win		
		4	23a. Part 1 Enter the disease, o	complications that caus	sed the death. Do	not enter the mode of dy				Approximate Interval Between
	Pnysician		shook, or heart failure. List Immediate Cause (Final	only one cause A each	Tille.	mia				Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or	as a consequence	o of):	4			
A	Examiner		Sequentially list conditions,	b. Pa	rkin	sons de	seas	۷		
	p tis	iner	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Directo (or	as a consequence	(af):				
	and I-tran	Examine	that initiated events resulting in death) Last	c. Due to (or	as a consequence	e of):				
760,	te be executed ysician and re burial-transit	calE		4						
687	9 × 6			0.						
Вох	leath certificat attending phy I for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnancy n 2 🗌 Fetal deat	th 3 Ectopic pregnance	ev		23d. Date of deliv	
	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death	5 Other (specify)	• • • • • • • • • • • • • • • • • • • •		Month	Day Year
P.0	at the de	Phy	9 Unknown			in the underhing enuse as	non in Part I	23e Did tobaco	n use contribute to	the cause of death?
	The law requires that the death certifice ate has been signed by the attending phage? should be detached for use as It	by	Part II. Other significant conditi	A HOOL	itus	in the underlying cause gi	venin ran.	1 ☐ Yes	2 <b>2</b> No 3 □ Pro	
0.0	w require been si should l	eted	- David	100 - 1-1	0, 11	ale		24a. Was an	24h Wara aut	tonsy findings available
Records,	has b	Completed	Caren	oma of	1011	ale		autopsy performed	? death?	topsy findings available ompletion of cause of
Vital		e Co	25. Was case referred to medica	1)			26 Place of Deal	1 ☐ Yes 2 ☐ th (Check only one)	No 1 Yes	2 No
>	Phyaician: this certific ral director,	OB	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inp	atient 2 ER/C	Outpatient 3 DOA Ot		ome 5 PResidence	6 Other (Spec	ify)
1 of		T:U	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date of (Month,	njury 28b. Day Year)	. Time of 28c. Injury Wo		28d. Describe how in		
io	andin sath. or: Af	atlo	2 Accident invest	igation		M 1	]Yes 2□No			
Division	l or Attendi after death. Diractor: A I in by the fu	Certification;	3 Suicide 6 Could 4 Homicide determ	200, Flace Of	Injury - At home, , etc. (Specify)	farm, street, factory, office		28f. Location (Street City or Town, St	and Number or Hu ate)	rai Houte Number,
	pital ours al		29a, Certifier 1 Certifyi	ng Physician. To the he	est of my knowled	ge, death occurred at the t	time, date and place.	and due to the cause	e(s) and manner as	stated.
	To the Hospital or Attending within 24 hours after death. To the Funaral Director; After completely filled in by the fune	edical	(Check only 2 Medica one)	Examiner: On the basi and manner	s of examination a	and/or investigation, in my	opinion, death occur	rred at the time, date	and place, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifi	ər			ise number	29d.	Date signed (Month	n, Day, Year)
			Ruka	ran		2	21449	L	lay 11.	2004
	9		30 Name and address of person	who completed cause	of death (Item 23a	(Type, Print)	1 1 5 . 1 -	A 15 A 1	1714000	10 21229
	\		JAMBANDA	M BASK	TRAN	5455 WI	LALWSI	アンレ ノンケ	שאטומו נש	114 -12-7
	St. Regist	ate rar	31. Date filed (Month, Day, Year	5 2004	istrar's Signature	South 1				
	riegisi			6' "	thch	A STORES OF THE STORES				

			For State Registrar	State	of Marylan		artment of H rtificate of I	lealth and M Death			2004	15592
ı	Physici	an	1. Decedent's Name (First, Middle RAFAEL (NMN) FU		LON				2. Date of De Month MAY		2004 <sup>Year</sup>	3. Time of Death 12:42P M
•	/Medic Examin		4a. Facility Name (If not institution National Inst:	, give street and no	ımber)		4b. City, Town, or Bethes	Location of Death			ounty of Death	
	Funeral Director		5. Social Security Number 583-06-3814	6. Sex 1 M 2 □ F	7. Age (In yrs. 45	last birthday) Yrs.			8. Date of Bir (Month, Da 03 30	th ly, Year)	9. Birth	y pplace (State or Foreign untry) Piedeas, P. F
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  P • R •			y, Town or Lo anovana			**			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the A 3e or 28a- it be notifi	Funeral Director	10e. Street and Number Pepita Albano	los #109			10f. Zip Code 00729			10g. Citizer	n of What Co	untry?
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumatic event, Ite Madical Ext. ill art. ust be notified at once.	ē	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was De Armed F	2 ⊠ No ive			ispanic Origin? (Sp In, Mexican, Puerto Specify: Puer			Race - Amer Black, White pecify: B1	e, etc.
N-6171	within 72 hou ene. then "nature re Moulical E	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 12th	st grade completed	) (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired Barber	during most of work	ing		of Business/l	
land 2	uld be filed Aental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Middle, Alfonso Fuent				barber	18. Mother's Name	_			F
, Mary	and 2 showealth and health and he		19a. Informant's Name/Relations Alfonso Fuentes		loop t	Pepit	a Alband	and Number or Run	anovana	s, P.	R. 007	29
altimore	t. Pages 1 tment of H tant: If ite		20a. Method of Disposition  1 ⊠Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	pecify)	Ctoto (	cemetery, crer nicipal		5-16		Canova	anas P	.R.
ga	permit Depar Impor any ir		21. Signature of Funeral Service	shall	caused the deal	42	17 9th. S	St. N.W. V	Washing	ton, I		0011 Approximate
	Pnysician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a/	each line.	quence of):	Failure	1				Interval Between Onset and Death
	Examiner	liner	Sequentially list conditions, lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Vinen, or as a consac	(uence of):	tdus."in	lym,	hinn			MI-ths
8/60,	icate be executed physician and s the burial-transit	dical Examine	that initiated events resulting in death) Last	c Due to	o (or as a consec	quence of):						
O. Box 6	that the death certific hed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregn birth 2 Feta gnant at time of c nown	aldeath 3□	□Ectopic pregnancy □ Other (specify)	,		230	d. Date of deli Month	very Day Year
rds, P.	law requires that t as been signed by 2 should be deta	þ	Part II. Other significent condition	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	_	cbacco use		the cause of death?
Vital Records,	The ate h page	Completed							24a. Was auto perfo		24b. Were aur prior to death? 1 \( \text{Yes}	topsy findings available ompletion of cause of
VIE	Physicien: r this certific ral director,	o Be	25. Was case referred to medica examiner?  1 Yes 2 No		¶Rpatient 2□	ER/Outpatier	at 3CI DOA Oth	er: 4 ☐ Nursing Ho			70th as /Cons	
on of	ding Phy n. After this funeral d	-	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Dat (Mo	e of Injury enth, Day Year)	28b. Time o Injury	f 28c. Injur Wor		28d. Describe			ary)
Division	al or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Flat buil	ding, etc. (Speci	(ty)	reet, factory, office		City or To	wn, State)		ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical one)		be best of my known basis of examination of examination of examination of the control of the con	owledge, deat ation and/or in	vestigation, in my d	pinion, death occur	and due to the red at the time,	date and pl	lace, and due	to the cause(s)
)	To the within 2 To the complet	Z	29b. Signature and title of certific	> 1/2	on P			e number 234888	VA	29d. Date s	signed (Month $2/2$	, Day, Year)
	3		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print) 10 CEI	NTER DRIV	Е, ВЕТН	ESDA,	MD 208	392
	Sta Regist	ate rar	31. Date filed (Month, Day, Year, MAY 1 5 20)	400	Registrar's Sign	ature	٤,					

		For State Registrar	State of M	Maryland				ealth a Death	nd M	ental		ene 1. No. 2 (	004	15593
Physicia	an	1. Decedent's Name (First, Middle,		. 7 -						2. Date of	of Death	Day	Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution,		ola		4h. City	Town, or	Location of		May	15,	2004 4c. Count	y of Death	11:59 P M
Examin	er	Gilchrist		′/		45. 54,	Tows		, , ,				timor	e
Funeral Director		5. Social Security Number 209-30-6138		Age (In yrs. la: 84	s <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of (Mont) May	of Birth h. Day, h 15,	1920	9. Birthp Cour I t	place (State or Foreign htry) a ly
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Limits
e Man 3e-f sh Liffied	ctor	PA. Westmor	eland		Vande									1 XYes 2 No
with the or 24	Funeral Director	10e. Street and Number				10f. Zip					100	g. Citizen of	What Cour	ntry?
death ms 23	neral	503 Sycamore St	12. Was Deceder		i. 13. \		.5690 lent of Hi	spanic Orig n, Mexican,	jin? (Spe	cify Yes	or No-	14. Ra	ce - Americ	
Dallilliore, Intal ylailid ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, I'r. Medical Examination in the motified at once.	by	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces d 1 ☐ Yes 2 1 If Yes, Give Year or Dates	ĮΝο		1 ⊡ Yes	-	Specify:	, rueito r	ncan, etc	i. j	Specia	ick, White, fy: Wh	ite
"netur	Completed	15. Decedent's (Specify only highest			16a. Deced	tent's Usua kind of wo	rk done d	furing most	of workin	ng	16	6b. Kind of E	Business/In	dustry
d withir jiene.	ошо	Elementary/Secondary (0-12)	College (1-4o	r 5+)	<i>m</i> 0. <i>t</i>		codia					Publi	c Sch	ools
drice d be filed intal Hyg ed othe	Be C	17. Father's Name (First, Middle, La	ast)	· · · · · · · · · · · · · · · · · · ·				18. Mother	r's Name	(First, M	iddle, Ma	aiden Surna	me)	
should be nd Mental marked c	2	Leonardo [	o (Type Print)		19h Mailir	na Address	(Street a	As	sunt	.a I Boute N	Giov	annan	geli State Zin	Code)15690
nd 2 si			Cola Wife	•								t, Pe		
DallIIIIOre, permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other		20a. Method of Disposition  1 Burial 2 Cremation	B □Removal from Stat	te <i>cei</i>	ace of Dispo metery, crer	sition (Nau	ne of ther place	9) 5		ate	20	nderg	- City or To	
allinor mit. Pages partment of portent: If it y injury or o		* 4 □ Donation 5 □ Other (Special Signature of Futural Service L		it St.				leum			1	Pe	nnsyl	vania me, Inc.
Depa Depa Impo		Paul W	thoan									rylan		204
Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	nly one cause on each	line.				g, such as o	cardiac or	r respirat	ory arres	t,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or a	as a conseque	ence of):	3-1210	-						-	months
Examiner	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a conseque	ence of):									
be executed incident and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		anno of):									
ile bask nysician he burial	dical Ex		Due to (or a	as a conseque	erice or).									
a sa	Medic	ICCCM IC												
death certifical death certifical death certifical death certifical death death certifical death	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom  1 Live birth  4 Pregnant	2 Fetal	death 3	Ectopic p						1	ate of delive onth	ery Day Year
the de or the de ached	hysic	1 Yes 2 No 9 Unknown	9 Unknown		atii 5		ecily)							
w requires that the death cer been signed by the attending should be detached for use	by	Part II. Other significant condition	s contributing to death	but not resul	Iting in the u	nderlying o	ause give	en in Part I.				cco use con	tribute to th	ne cause of death?
N 60 8 61	Completed										Was an autopsy	24b.	Were auto	psy findings available impletion of cause of
ate pag										101		ed? No	death?	2 <mark>5</mark> €No
	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ ➡ o	Hospital: 1 ☐ Inpa	utient 2 E	R/Outpatier	nt 3□ DC	Othe	26. Place er: 4 ☐ Nur	-			ce 6 TOt	her (Specif	WN. CISPICE
on or ding Phys h. After this funeral di	tlon: T	27. Manner of Death  Panatural 5 Pending 2 Accident investigs	28a. Date of Ir (Month, L		28b. Time of Injury	M	28c. Injury Work		2			injury occu		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
JIVISION  or Attending after death. Director: After	ertification:	2 Accident Investigation 3 Suicide 6 Could not determine	ot be 28e. Place of	Injury - At hon etc. (Specify)	me, farm, str	eet, factor	y, office		2		ion (Stre or Town,		ber or Rura	I Route Number,
DIVISION OF To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical Ce		Physician: To the be- xaminer: On the basis and manner	of examination										
To the within To the comple	Med	29b. Signature and title of certifier	1			29	c. License				290	d. Date signe	ed (Month,	Day, Year)
		Menen	unn			L	55	330	3			144	16	2009
12		30. Name and address of person w	the completed cause o	f death (Item	23а) (Туре,	Print)	anle	sSt	Bo	ilte	nur	e mi	7212	204
Sta Registi		31. Date filed (Month, Day, Year)	f -d 100	strar's Signatu	ure	c do	sadi	3				e mi		

	1 - For State Registrar		of Maryland		artmen rtificat			and M		Reg. No. 2	004	1559
Physician /Medical Examiner	Decedent's Name (First, Gertrude  4a. Facility Name (If not ins Brighton Garde)	Doering titution, give street and				Town, or umbia	Location o		2. Date of De May 13,	2004 <sup>ay</sup>	Year Dunty of Death	7:45 PM
Funeral Director	5. Social Security Number 212-01-9523 Usual Residence of Deced	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D June 21			place (State or Forei intry) INY
iffied at	10a. State 10b. C			, Town or Lo umbia		-						10d. Inside City Limi
r tems 23e or 28e-f el miner aust be nutified Funeral Director	7110 Minstrel			12		045	annia Ori	-in2 /Cna	noity Voc or N	U.	S.A. Race - Amer	
by by	11. Marital Status  1 Never Married 2[ 3 WWidowed 4 Dri	☐ Married 1 ☐ Ye	ecedent Ever in U.S Forces? s 2 XNo Give r Dates:		vvas Deced If Yes, spec 1 ☐ Yes		Specify:	i, Puerto	ecify Yes or N Rican, etc.)	S	Black, White	i, etc.
	15. De (Specify only Elementary/Secondary (	ocedent's Education highest grade complete 0-12) College	ed) e (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us <b>remaker</b>	rk done d se retired	ation fu <i>ring m</i> os )	t of worki	ng		of Business/li	ndustry
even Be	10-07	ishop		10h Maili	o - Addroos	(Street o	unkr	own	(First, Middle unkno	WN	umame) Town, State, Zi	in Code)
7 is trau		ing - Son	20h PI		Field	Court		iada,	CO 80005		tion - City or T	
Department of Healt Importent: If item 2 eny injury or other once:	20a. Method of Disposition  1  Burial 2	nation 3 Removal fro ther (Specify)	om State	rkwood (	matory or o Cemeter	ither piac 'Y	Ę	5/17/0		Baltir	nore, Mai	
Depa Impo eny i	23a. Part1. Enter the dise shock, or heart failur	Then (	rei		5305 H	larfor	d Road	d Balt	imore, N	Marylano		Approximate
attending physician and for use as the burial-transit and lan/Medical Examiner		b. Due	to (or as a consequence to (or a))).	ience of): ience of):	HIZ							o year
cate has been signed by the attending ph. page 2 should be detached for use as th Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1  Yes 2 No 9  Unknown	ant s? 1⊡Liv 4⊡Pr	outcome of pregna /e birth 2  Fetal egnant at time of de nknown	death 3[	⊒Ectopic p ⊒ Other <i>(sμ</i>					23	d. Date of delin	very Day Year
n signed by uld be detac	Part II. Other significant of Dysphas	_	o death but not rest	alting in the t	anderlying o	cause givi	en in Part	l. 		tobacco use		the cause of death?
ate has been single 2 should t									24a. Wa auto peri 1 🗆 Yes	s an opsy formed?	24b. Were aul prior to c death? 1 \( \text{Yes}	topsy findings availa completion of cause of 200 No
this certifical director	25. Was case referred to examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1	☐ Inpatient 2☐ ate of Injury Month, Day Year)	ER/Outpatie 28b. Time o Injury		28c. Injun Wor	er: 4 □ Ni yat	ursing Ho	n (Check only me 5 ☐ Res 28d. Describe	idence 6	XOther (Spec occurred	Living Living
rs after death. rel Director: After to led in by the funera Certification:		p.	ace of Injury - At ho uilding, etc. (Specif)	/)	59,144				City or To	own, State)		ral Route Number,
within 24 hours after death. To the Funerel Director: Atter completely filled in by the tuner Medical Certification	29a. Certifier (Check only one) 2 N		the best of my kno the basis of examina manner stated.	wledge, dea tion and/or in	rvestigation	c. Licens	ne, date ai pinion, dea e number	ath occurr	red at the time	, date and p	signed (Month	to the cause(s)
10	30. Name and address of	person who completed	cause of death (Item	23a) (Type	, Print)	W .	207	21		05	114/2	004
7	Harry L  31. Date filed (Month, Da	10 +8	2. Registrar's Signa	ture	Kiag	e K	oca,		Ellim	0100,	VILVE	~1-TT

DHMH 17 Rev 1/2001

ORIGINAL

/Medic	an	1. Decedent's Name Marjo	rie De									2. Date of Dea Month 3/20/		Year	3. Time of Death 8:10am M
Examin	_	4a. Facility Name (II				ber)				Location o	of Death		4c. Coun	ty of Death	
Funeral Director		1807 Hu: 5. Social Security N 282–32–1		er, Run 6. Sex 1□ M 3	7	7. Age (In yrs. 67	last birthday) Yrs.		bril 1 Year Days	IS If Under Hours	24 Hrs. Min,	8. Date of Birth (Month, Day	Ann 22,193	9. Birth	indel County place (State or Foreign intry) OH
		Usual Residence of						1				сере.	22/173	Ψ	
should be seen within 2 four after death with the waryand Mantal Hygene in matural, or items 23a or 28a-f show maked other than "natural," or items 23a or 28a-f show umatic event, if a Medical Examinational be coulded at	lor	10a. State CH	10b. County	Lucas		10c. Ci	ity, Town or Lo	ocation		Toleda	)				10d. Inside City Limits 1 XXes 2 □ No
a or 28s	i Director	10e. Street and Nun 751 Regina		у У				10f. Zip		3612			10g. Citizen o	f What Cou	intry?
Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 ehow any injury or other traumatic event, the Medical Exambles must be notified at once.	by Funeral	11. Marital Status  1 Never Marri 3 Widowed		ned 1	/as Deced med Ford ☐ Yes 2 Yes, Give ear or Dat	2 XNo		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or No- Rican, etc.)		ack, White	can Indian, , etc. white
Medical E	Completed	(Spec	15. Deceden	st grade com		4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d	urina mosi	t of worki	ng	16b. Kind of	Business/Ir	ndustry
3	Com	12				0		S	ecret	tary				Educa	tion
itic eveni	To Be	17. Father's Name (	(First, Middle, ampton	Smith								(First, Middle, e Agnes		ime)	
r trauma		19a. Informant's Na John DeHa			rint)							Route Number		n, State, Zi <sub>i</sub> 8250	p Code)
y or othe		20a. Method of Disp 1 Burial 2	Cremation		al from St		Place of Dispo cemetery, crea VView (	matory`or o	ther place	Tng		ate 22/2004	20c. Location	-	
mportan any injur- once.		21. Signature of Fu			ctor I							al Home,		INOLE	T-IID
		23a. Part1. Enter th			-> A								/   / 7		
er	licai Examiner	shock, or hear Immediate Cause ( disease or condition resulting in death)  Sequentially list con- itary, leading to in- cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	rt failure. List (Final in in inditions, imediate orlying injury	a b	Due to (o	or as a consector as	quence of):		e of dying			r respiratory arr			Approximate Interval Between Onset and Death
og physician and as the burial-transit as the burial-transit		shock, or hear Immediate Cause (disease or condition resulting in death)  Sequentially list conflicting to indicause. Enter Under Cause, Disease or that infittated events	rt failure. List (Final in  Inditions, indit	a b c d	Due to (or  Live bin	or as a consector as	quence of):  quence of):  quence of):  ancy al death 3E	ter the mod	e of dying				est,	ate of delivionth	Interval Between Onset and Death MONTM
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ate has been signed by the attending physician and more page 2 should be detached for use as the buriat-transit or or page 2.	by Physician/Medicai	shock, or hear Immediate Cause (disease or condition resulting in death)  Sequentially list confiarry, feating to indicause. Enter Under Cause (Disease or that infittated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, inditions, i	a b c d	Due to (or  Due to	or as a consector as	quence of):  quence of):  quence of):  ancy al death 3 [ feath 5 [	ter the mod	e of dying	, such as		23e. Did tol	23d. D M bacco use cor n 24b mgd?	ntribute to t	ery Day Year  he cause of death?
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ate has been signed by the attending physician and Union page 2 should be detached for use as the burial-transit or or page 2.	Certification; To Be Completed by Physician/Medical	shock, or hear Immediate Cause (disease or condition resulting in death)  Sequentially list confliction and sequentially list conflictions. Enter Under Cause. Enter Under Cause. Enter Under Cause (Disease or that infriated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	red to medical  No  h  5 □ Pendin  investit  6 □ Could determ	a.  b.  c.  d.  23c. If 11 4 99  pons contribut  Hospit.  19 gation not be 286  19 gation not be 286  19 gation Examiner: C	Due to (or  Live birt  Pregnar  Unknow  Unknow  ting to dea  al: 1 Ing  a. Date of (Month,  e. Place or  building	or as a consector as	quence of):  quence of):  quence of):  quence of):  ancy al death 3E death 5E sulting in the u  BER/Outpatier 28b. Time o Injury	□Ectopic pr □ Other (sp  inderlying ca  the sectory of the sector	egnancy ecity)  ause give  A Othe 8c. Injury Work 1 Y	n in Part I.  26. Place  7. 4 Nu  at ?  9. es 2 !	of Death rsing Hon 2 No 2 d place, a	23e. Did tol 1 Yo  24a. Was a autopo perform to yes.  Check on your to yes.  8f. Location (St. City or Town at the time, did at the time, did	23d. D  bacco use cor  as 2 No  n 24b  yearce 6 100  ow injury occu  reet and Num  7, State)  ause(s) and m  ate and place	Intribute to to a series of the series of th	ery Day Year  he cause of death?  pably 4 Unknown  posy findings available impletion of cause of  2 No  Impletion of cause of  2 No  Impletion of cause of  2 No  Impletion of cause of  2 home
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			1- For Amend Item Registrar	25 State	nd Marylar	192//8999 Cei	yamen tificate	t of H	ealth a	and Menta		ene 2001	15596
		П	1. Decedent's Name (First, Middle,	Last)							te of Death	_	3. Time of Death
	Physici /Medio		MARGARET		F020	K					lay i	Day Year 2002	
)	Examir		4a. Facility Name (If not institution,			010 6		Town, or	Location	of Death	0	4c. County of Dea	ath
			Johns Hopkens  5. Social Security Number	5. Sex	W Medica.		If Under	JUN	AVV Q If Under	24 Hrs.   0. D.	18:4	////	4
Г	Funeral Director		219–10–0460	1 ☐ M 2 💢 F			Months	Days	Hours	Min. (Mo	te of Birth onth, Day, Y ber 14,	(ear) 9. BI	rthplace (State or Foreign Country)
	D		Usual Residence of Decedent							, www	ACIL 13,	, 1525	, ID .
	arylar show	-	10a. State 10b. County			ity, Town or Lo							10d. Inside City Limits
	he M	Director	MD. N/A			Baltimo					1		1∑Yes 2 No
	with the or	Ö	815 S. Bouldin	Street			10f. Zip		1224		100	g. Citizen of What C USA	Country?
	ns 23	Funeral	11. Marital Status	12. Was De	ecedent Ever in U	J.S. 13. \	Vas Deced			gin? (Specify Ye	es or No-	14. Race - Am	erican Indian.
9	or Iter		1 Never Married 2 Marrie	d 1 ☐ Ye	Forces? s 2 No		fYes,spec I⊡Yes 2			gin? (Specify Ye n, Puerto Rican,	etc.)	Black, Wh	ite, etc.
903	ural',	d by	3 ☐ Widowed 4 🎇 Divorced	If Yes, 9 Year or	Dates:		1 1 1 1 es 2	ZKN NO	Specify:			Specify: W.	hite 
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Items 23a or 28a-1 show with the Madical Examiner must be natified at	Completed	15. Decedent's (Specify only highest		d)	16a. Deced	lent's Usua kind of wor	k done d	ation luring mos	t of working	16	6b. Kind of Business	s/Industry
12	within than than	dwc	Elementary/Secondary (0-12) 12 years	College	(1-4or 5+)		)usewi		,			Own Home	
	Hyg other	Be C	17. Father's Name (First, Middle, L	ast)		110	, abella		18. Mothe	er's Name (First,	Middle, Ma		
/lar	should be nd Mental marked c	To B	Frederick Kling	enhofer					Jen	nie Kac	zmarek	ς	
Maryland	C1 02 00 00		19a. Informant's Name/Relationshi	р (Турө, Print)								City or Town, State,	
	1 and Health em 27		Cynthia Ryan	Daught		16013 Place of Dispo			narin			Airy , MD	
Baltimore,	Pages 1 nent of h int: If ite iry or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation		m State	cemetery, cren	natory or ot	ther place		Date		c. Location - City o	
臣	permit. Page Department Important: If any injury or once.		<ul> <li>4 □ Donation 5 □ Other (Sp.</li> <li>21. Signature of Funeral Service L</li> </ul>		Sac				1	/ay 17,200		undalk,MI	
Ba	permi Depa Impo any it		1 ( but home	C. (	ا مر مرد	00, 5	onnel	Ty I	uner	ál Home	Of Du	ındalk, P ındalk,Md	.A.
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications tha	t caused the deal	th. Do not ente	er the mode	of dying	g, such as	cardiac or respi	ratory arrest	t,	Approximate
	Physician		Immediate Cause (Final disease or condition	nly one cause or	EUMC		9						Interval Between Onset and Death
	/Medical		resulting in death)	a. Due t	o (or as a consec		. (						
	Examiner	,	Sequentially list conditions.	b. 56	PSIS	<u> </u>							
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue t	o (or as a consec	(luence of):	ena.	7	Town w	4			
	xecut and	хап	that initiated events resulting in death) Last	c. Due t	o (or as a conseq	quence of):	1011	- / -	CI	4	Λ	111	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	alE		d						_ /	1 ///	EXAMINER	
9	tificati g phy as the	Physician/Medical								THE TON APPR	TO WE	DICAL EXAMINATION	
Вох	that the death certific ed by the attending pl detached for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pre	ennancy		TON APPR	ONED	23d. Date of de	
0	e dea he att	sicia	in the past 12 pronths? 1 2 Yes 2 2 No		gnant at time of o		Other (spe		CEF	SULIO!		Month	Day Year
<u>Ч</u>	hat th od by detach		9 ☐ Unknown ` Part II. Other significant condition	s contributing to	death but not res	culting in the up	darking on		n in Part I		o Did tobac	nas uso sastributo t	o the cause of death?
ds,	signed d be del	d by	(HRONTC C	125 TV	11/(TT)	Co Post	1 1/1/10	WA / 12	1.77 M	23	Yes		robably 4 Unknown
Sor	w requir	Completed	nschach	1 MM C	nnnn	Dr. 7	COL	in	TOG	AC6 24	a. Was an		
Be	ysician: The lav is certificate has director, page 2	duc	HICTORY		7 107	- P(K)	CK	1 10		77.7	autopsy performe	d? prior to death?	utopsy findings available completion of cause of
tal		0	25. Was case referred to medical	UF 5	WOK.	LIVO			26 Place	of Death (Chec		No 1 ☐ Yes	3 2 □ No
<b>Ş</b>	nysici nis cer direc	To B	examiner? 1 ∰¥es <del>- Ž⊊ No</del>	Hospital:	Inpatient 2	ER/Outpatient	3 DO/	A Othe				e 6 □Other (Spe	ecify)
Division of Vital Record	ng Pt		27. Manner of Sath	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28	Bc. Injury Work				injury occurred	
sio	tendi Jeath. tor: A the fu	cati	2 Accident investiga	t be			М		es 2□N				
$\leq$	or At after d Direct in by	Certification;	4 Homicide determin	ed 286. Pla	ce of Injury - At he Iding, etc. (Specif		et, factory,	office		28f. Loc City	ation (Stree y or Town, S	et and Number or R. State)	ural Route Number,
_	spital ours a neral filled		29a. Certifier 1 Certifying	Physician: To the	he best of my kno	owledge, death	occurred a	it the time	e date and	d place, and due	to the caus	se(s) and manner as	stated
	To the Hospital or Attending Physician: whith 24 hours after deals after deals To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	(Check only 2 Medical E	(aminer: On the	basis of examina anner stated.	ation and/or inv	estigation,	in my op	inion, deat	h occurred at th	e time, date	and place, and due	to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifles		0.			License			29d.	Date signed (Mont	h. Day, Year)
7	10		▶ BEENLEIX		DR. NO			es-1	000		/	May 13	12004
			30. Name and address of person w		use of death (Item	n 23a) (Type, F	Print)	801	AVC	n/112 1	2015	TIM I COS	217711
	Sta	te.	OR NOUR JOHNS 31. Date filed (Month, Day, Year)		Registrar's Signa	14-140 ature	1010	W/V	11167	IVVIC I B	771_	LIMORE	1016601
	Registr		MAY 1 7 20	04 5	neva	19	Spa	Karl	7				, 21224.

			For State	ate of Maryland				Mental Hyg	iene	
			Registrer		Certi	ificate of E	Jean	2. Date of Deal	eg. No. Z U U L	3. Time of Death
ı	Physicia		1. Decedent's Name (First, Middle, Last)  Bonnie L	F	ulghi	UM		Month	Day Year	Q IUD D.
}	/Medic Examin		4a. Facility Name (If not institution, give street Johns Hopkins	t and number) Bayview	4	4b. City, Town, or Baltin			4c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or, Foreign
	Director		212 42 1106 10M	201F LO	Yrs.	Months Days	Hours Min.	Oct. 20	1943 P	lary And
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Loca	ition				10d. Inside City Limits
	Maryli fed a	Į.	Maryland Baltimore		undali					1 Yes 2 □ No
	r 28a	Director	10e. Street and Number	^		10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23a c		3016 Liberty	Parkway			222		United	States
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, the Medical Evant er must be notified at or other traumatic avant, the Medical Evant er must be notified at	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? I □ Yes E 2 M No f Yes, Give Year or Dates:	_	as Decedent of His es, specify Cubar Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade co.		(Give kit	nt's Usual Occupa nd of work done d	urina most of worl	king	16b. Kind of Business	/Industry
121	filed within 72 Hygiene. other than "natern" and ant, the Medic	mp		College (1-4or 5+)		NOT use retired)			Dwn H	ome
9	filed with Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i		
aryland 21215-003	should be and Mental s markad o umatic ava	To B	JACK L. RYA	П			Ilear	1A B	obo	
lan)	2 sho		19a. Informant's Name/Relationship (Type,	1 1	19b. Mailing 2403	- 11		BAlhmo	; City or Town, State,	
ė,	1 and Health em 27		Brandi Fulghum /	davahier 20b. Place	ce of Disposit	ion (Name of	AVE		20c. Location - City or	21222 Town, State
ē E	Pages nent of int: If it		1 ☐ Burial 2 🔀 Cremation 3 ☐ Remo	val from State		Cremator	4.4	17 2004	Balhmore	Maryland
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other Once.		21. Signature of Funeral Service Licensee	\ <u>i</u>		Name and Address	1	Dyndaly	Dundalk, P.	222
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death.			, such as cardiac	or respiratory arr	-	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sepsis						Onset and Death  A days
	/Medical Examiner		resulting in death)	Bowel Pr		ation				14 days
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer		C I C I				
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Circhosi						1 year
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequer	nce of):					
687	ficate I physics the b	edical	d							
Box (	h certii ending use a	In/Me	230. was decedent pregnant	If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de		ctopic pregnancy			23d. Date of de	
	The law requires that the death certificate be executed to has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	4□Pregnant at time of deal 9□Unknown		Other (specify)			Month	Day Year
٥.	res that the signed by be detact	/ Ph	Part II. Other significant conditions contrib	uting to death but not resulti	ing in the und	erlying cause give	n in Part I.	23e. Did to	pacco use contribute to	the cause of death?
Vital Records,	w requires been sign should be	ed by						1 □ Y	es 2 No 3 □ P	robably 4 Unknown
eco	ne law requ has been ge 2 shoul	Completed						24a. Was a	y prior to	utopsy findings available completion of cause of
<u> </u>		Соп						perform 1 Tes	ned? death? 2. No 1 ☐ Yes	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital:	20.	2□ DOA Othe	r	th (Check only on		
of	iing Phys n. After this funeral di	lon: To	1 XNatural 5 ☐ Pending		8b. Time of Injury	28c. Injury Work	at Nursing H		ence 6 Other (Spe	city)
Division	or Attanoster deall Diractor: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hom- building, etc. (Specify)	e, farm, stree			28f. Location (Si City or Town	reet and Number or R. n, State)	ural Route Number,
_	To the Hospital or Attanding Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	edical Co		an: To the best of my knowle On the basis of examination and manner stated.						
	To the within To the comple	Med	29b. Signature and title of certifier			29c. License			9d. Date signed (Mont	
	n		1307	MD		RES	-000	1	May 16,	2004
	,7		30. Name and address of person who comp	eted cause of death (Item 2	(Type, Pi	ife Stre	et B	altimon	e,MD 2	1287
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 7 2004	eted cause of death (Item 2 600 North 32. Registrar's Signatur	re A	fra v	., 3			

		riease i	ype or Print in Bla			-		
		For State	State of Maryland /	Certificate of			2001	. 15500
	4	Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of	Dealli	Reg.	No. 4 U U L	3. Time of Death
Physicia /Medica			Dorothy B.	Forish		Month	Day Year	18:00PM
Examine		4a. Fecility Name (If not institution, give	treet and number)	4b. City, Town,	or Location of Dear	th	4c. County of Deal	h
		Franklin Squa	re Hospita	birthday) If Under 1 Yea	r If Under 24 Hrs			ore
Funeral Director	İ	5. Social Security Number 7 6. Sex 213-20-4649	7. Age (fn yrs. last i	Yrs. Months Day		(Month, Dey, Ye	1	thplece (State or Foreign
D		Usual Residence of Decedent				Aug. 15,	1925   Ma	ryland
ehow	5	10a. State 10b. County		own or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M	Director	Maryland Balt  10e. Street and Number	imore	10f. Zip Code	Colgate	10g	Citizen of What Co	**
		7702 Gough Stree	t	10.7 = 1,5 0000	21224	l veg.		
deat	Funerai		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cu		Specify Yes or No-	United S 14. Race - Ame Black, Whit	nican Indian,
2-UUSO 72 hours after naturel; or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1	1 □ Yes 2√2 N		to ritoani, otc.)	Specify:	e, etc.
2-UUSO 72 hours af		15. Decedent's Edu		Sa. Decedent's Usual Occ	unation	166	1 ' '	hite
within 72 ene. then 'na	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of work don life. DO NOT use retir	e during most of wo	rking	. King of Dasifies	moustry
d Z I.	S	11 Years	33.1333 (1.1373.1)	Housewife	e		Own Ho	me
	Be	17. Father's Name (First, Middle, Last)				me (First, Middle, Maid	,	
should be the Mental or marked umatic ev	၉	Joseph Pospisil  19a. Informant's Name/Relationship (Ty	ne Print) 19	9b. Mailing Address (Stree		ella Vacovs		Zin Codol 21227
Magazine San San San San San San San San San San		Michael A. Forish		8366 Old Ph			sedale, M	
os 1 and 3 Health Hem 27 cother tr	Î	20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other pi			. Location - City or	
Baltimore, permit. Pages 1 at Department of Heal Important: If the Important of the Once.		Mathematics	emoval from State	ens of Faith	1	/14/2004	Rosedale	, Maryland
Dan Demir. Depart Import Import Import Import Import Import		21. Signature of Funeral Service License	\$ () ()	22. Name and Add Duda-Ruck	Funeral	Home of Du	ındalk. T	
202.0		222 Pad Fater & disease John 6	ortions that sound the death D	1922 Wise	e Ave. Di	indalk, Mar	yland 2	1222
		23a. Part1. Enter h disease. complishock, or he did he list only or immediate Cause (Finaf	e cause on each line.					Approximate Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	Due to (or as a consequence	ic brec	ast co	incer		
Examiner		Sequentially fiet conditions						
Z =	ner	Sequentially fist conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a consequence	e of	•			
be executed loian and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequenc	e of):				
Pur Bicin	rg		,	J 3.7.				
O. BOX 687, 1987,	Physician/Medic						172	
ath cert	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 ☐Ectopic pregnan	cv		23d. Date of del	,
the dea ched fo	/s c	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of death 9☐ Unknown	5 ☐ Other (specify)			Month	Day Year
hat the sed by detac		Part II. Other significant conditions cor	tributing to death but not resulting	in the underlying cause o	iven in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
w requires to been signed should be a	d by	Hyperter	sion C.	H. F		1 🗆 Yes	. /	obably 4 Unknown
law req as beer 2 shou	Completed					24a. Was an	24b. Were au	topsy findings available
The la	E					autopsy performed 1 ☐ Yes 2 🛣	? death?	completion of cause of 2 No
VICAL ME Incian: The lar certificate has rector, page 2	Be	25. Was case referred to medical examiner?				ath (Check only one)	10 101	
OT VICA Physician: r this certific	၀	10195 2110		Dutpatient 3 DOA		lome 5 Residence		cify)
E g ef e	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b	Time of Injury M 28c, Injury W	ury at ork? □Yes 2□No	28d. Describe how in	njury occurred	
UNISION I or Attending after death. Director: After	ifica	3 Suicide 6 Could not be	28e. Pface of Injury - At home, building, etc. (Specify)			28f. Location (Street		iral Route Number,
tal or rs afte al Dir	Certification:	4   Horricide	building, etc. (Specify)			City or Town, St	a(e)	
	edical	(Check only 2 Medical Examil	sician: To the best of my knowled ner: On the basis of examination a	ge, death occurred at the and/or investigation, in my	time, date and place	a, and due to the cause	e(s) and manner as	stated.
thin 2 the posterior	Med	one)  29b. Signature and title of certifier	and manner stated.		nse number		Date signed (Month	1
F % F S		) Ch X On	& mD	D 5	1.381	5	-11-	04
10		30. Name and address of person who co	mpleted cause of death (Item 23a	ı) (Type, Print)	10101			- (
10		Dr. Josephin Ow	usu-Salbyi	1000 Frankl	in Squal	e Drive B	altimore	MD 31237
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	2.0	0			•

State of Maryland / Department of Health and Mental Hygiene 599 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William W. Ford MAY 11,2004 3:15P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Saint Joseph Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 5, 10 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F 1922 Maryland 216-16-2150 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or Itema 23a or 28a-1 show or other traumatic event, the Medical Examinar must be rediffied at 1 ☐ Yes 2 X No Director Md. Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21204 8432 Charles Valley Ct. Apt D Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Exemples 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Accounting Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Reba Spedden William H. Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1106 Walnutwood Rd. Cockeysville, Md. 21030 Mr. Thomas H. Ford/ Son 20b. Place of Disposition (Name of cemetery, crematory or other p. 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date Dulaney Valley Mem. 5-14-04 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) Towson Funeral Home, York Rd. Towson, Md. 21. Signature of Fuperal Service License Approximate Interval Between Onset and Death 23a. Part1/Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE MYDCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a ld be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES MELLITUS page 2 s autopsy 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 NInpatient 2 ER/Outpatient 3 DOA 2 Director: After this in by the funeral di Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05-11-04 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 FRANCIS KHOO M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 001 15600 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:50 AM JANE MAY FOULK mar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 KF 49 233-92-1409 Director WEST VÍRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No HEDGESVILLE **Funeral Director** BERKELEY 10e. Street and Number 10f. Zip Code 10g. Citizeri of What Country? USA 95 TRIBAL COURT 25427 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X XMarried Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WESTERN EXPRESS al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) TRANSPORTATION DRIVER/MANAGER 12 ages 1 and 2 should be filed on of Health and Mental Hygie t: If item 27 Is marked other ty or other traumatic svent. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOLDIE RORABAUGH EDWIN SICERO CODY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 95 TRIBAL COURT, HEDGESVILLE, WV 25427 ALAN WILLIAM FOULK/SPOUSE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 PLEASANT Crematory or other place)
PLEASANT VIEW
MEMORY GARDENS 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or MARTINSBURG, WV 15, 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. UX 221, 327 W. H MARTINSBURG, WV acles m Mawa the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) 11.2C **Physician** noma MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and physician ar Due to (or as a consequence of). Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by mongsi 1 Yes 2 □ No 3 Probably 4 □Unknown as been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? almonou beadt 262/No 1 ☐ Yes 2 ☐ No certificate DWW 1 ☐ Yes of Vital XT YMV 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Certification: After Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by I 4 Homicide filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific e of death (Item 23a) (Type, Print) 30 Name and address of derson who complet 282 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar a series

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Day **Physician** 7:30 A M 2004 May /Medical Leroy William Fee 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** <u>Baltimore</u> Joseph Richey Hospice If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year Months Days **Funeral** Months Hours Min 87 Director 216-07-5747
Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show injury or other traumatic event, the Mcdical Examinar must be notified at X Yes 2 □ No Director Baltimore MD na 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number flems 23a or 21222 USA Apt. 104 2009 Bear Ridge rd. Funerai 12. Was Decedent Ever in U.S. Armed Forces?

\*\*Eyes 2 □ No 1 94 2
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1□Yes XINO Specify: White white "natural", or If Yes, Give Year or Dates: Specify: þ XXWidoweid 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumetic. Elementary/Secondary (0-12) 8th College (1-4or 5+) Roofer Roofing Company Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Gorth Eugene Fee Baltimoré, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Bear Ridge rd. Apt. 104 Baltimore, MD 21222 Carolyn Black -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery May8 2004 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilfens ave. Baltimore ave. 21229 23a. Part. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably peed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an autopsy performed? Yes 20 No 1 Yes fo the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Baltimore, MP

State Registrar

eROY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospice 838

Eutaw

		•	For State Registrar	State of M	<b>/lary</b> lan		rtment of F		Mental Hy	giene Rag. No. 2	004	15602
	Physicia	an	Decedent's Name (First, Middle,			71-1-1-1			2. Date of De Month		Year <b>ZOS</b> 4	3. Time of Death
	/Medic		John E. Fergusc		er)		4b. City, Town, o	or Location of Dea	-	4c. Cour	nty of Death	17:20
	LXammi		Saint Agnes	HEALTHE	ARE		BaHim		·	n.	a	
	Funeral Director		5. Social Security Number 216-32-4944	.Sex 7 XIXIM 2□F	Age (In yrs. 68	last birthday) Yrs.	Months Days	If Under 24 Hr Hours Mir		th ay, Year) -1935	9. Birthp Cour MD	
	pu *::a:i		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or Lo	ation				1	0d. Inside City Limits
	Aaryla f sho	ō	100			timore						XIX Yes 2 No
	r 28a-	irect	MD na  10e. Street and Number		рал	CIMOLE	10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	th with	al D	448 South Chap1	egate			21229			USA		
	ems erms	ner	11. Marital Status	12. Was Decede	s?	S. 13. V	as Decedent of H Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	o- 14. R	lace - Americ lack, White,	
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 la marked other than "natural", or items 23s or 28s-f show traumatic event, the McClical Ever it are must be multipled.	Completed by Funeral Director	1 Never Married 2 Marrie XX 3X Widowed 4 Divorced	1 1 Yes 2 [ If Yes, Give Year or Date:		1	☐ Yes XXX No	Specify: wh	ite	Spec	city: whi	te
5-0	72 ho 'natur	eted	15. Decedent's (Specify only highest			(Give	ent's Usual Occup and of work done	during most of w	orking	16b. Kind of	Business/Inc	dustry
121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4c	or 5+)	Couri	0 NOT use retire: >↑	a)		Flanis	gan an	d Sons
9	filed Hygie other ent,		17. Father's Name (First, Middle, La	ist)	····	Court	<u> </u>	18. Mother's Na	ame (First, Middle			d boils
ılan	Ald be Aental rked o	To Be	Welton Ferguson					Mary H	owe			
lary	2 short and halls ma		19a. Informant's Name/Relationshi	(Type, Print)		19b. Mailin	Address (Street	and Number or F	Rural Route Numb	er, City or Tow	vn, State, Zip	Code)
	C 4 7		John Ferguson Jr 20a. Method of Disposition	• son	20h F		Rockhill sition (Name of	ave. Ba	ltimore,		22 <b>9</b> n - City or To	wn State
nor	ages intoff h		1 ⊠Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe		te C	emetery, cren don Pa	atory or other pla			Baltomo	-	
Baltimore,	permit. Pages 1 a Department of Hei Important: If item any injury or othe		21. Signature of Funeral Service U		1200				al Home Baltimo			
_	99 2 2 2		23a. Part. Enter the disease, or c shock, or heart failure. List or	Many	que						21229	Approximate Interval Between
8760,	Physician Medical Medical Examiner  be attending physician and provided as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequence as a c	uence of):			Vasevi		reve	Onset and Death  Un ICh Own
$S_{\text{O. Box 6}}$	that the death certifics ed by the attending pt detached for use as t	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknowr	ı 2 ∏Feta tat time of d	Ideath 3□	Ectopic pregnanc Other (specify)	у			Date of delive	ny Day Year
n Asp	Se Co	by P	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the ur	derlying cause gro	ven in Part I.		tobacco use co Yes 2□No		ne cause of death?
Joh	aw as b	Completed			-				24a. Was auto perf 1 Yes		b. Were auto prior to condeath?	psy findings available impletion of cause of
/ifal	i <b>ician</b> : Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						eath (Check only	one)		
0 5	Physician: this certific	မ	1 ☐ Yes 2 No	Hospital: 1 Inp		ER/Outpatien	3D DOX		Home 5 ☐ Res	idence 6 C		y)
27	ding F h. After funer	tlon	27. Manner of Feath  Natural 5 Pending  Accident investiga	28a. Date of I (Month,	Day Year)	Injury	28c. injui Wo M 1	rk? ]Yes 2∐No	200. Describe	now injury occ	Julieu	
eRg US Division	l or Attendi after death. Director: A I in by the fu	Certification;	2 Accident     investigs       3 Suicide     6 Could not determine       4 Homicide     determine	t be 28e. Place of	Injury - At h	ome, farm, str	eet, factory, office			(Street and Nui wn, State)	mber or Rura	il Route Number,
120	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Ce		Physician: To the be kaminer: On the basis	s of examina							
	o the inthin 2 o the o the omple	Med	29b. Signature and title of certifier		statou.		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
	<b>⊢</b> ≯ <b>⊢</b> 0		) ) A	Kar in	N	1	170	1055849	7	Mou	17	2004
	3		30. Name and address of person w	ho completed cause of	of death (Iter	n 23a) (Type,	Print)	202	1 1	1 10	1.1-	we Marylon
	Sta	10	31. Date filed (Month, Day Year)	32. Rea	1910 istrar's Signa	ature 10.	MIGI	900 Ca	on then	we he	Tino	ve / aryon
1	Regist		MAY 1 7 20		ner	B	apakr					

State of Maryland / Department of Health and Mental Hygiene 2004 15603 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2004 **Physician** May 11, 1453 P <sup>™</sup> Ghee Mae Dorothy /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 200 Yrs. 66 Director VA 216-42-1382 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or itams 23a or 28a-f show Examiner must be notified at XXYes 2 No Baltimore MD NA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 U.S.A. 2210 Sidney Ave filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black \*natural Completed It's Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) House Keeping Johns Hopkins Hosp. 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental 27 is marked or traumatic ever Bertha Taylor Wiley Ghee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i 3214 Gulfport Drive, Baltimore Md 21225 LaTonya N. Ghee-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or otl
once. Burial 2 Cremation 3 Removal from State King Memorial Park 5/18/04 Randallstown, Md \*4 □Donation 5 □Other (Specify) 21. Sign un of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 shompson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, di heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due 1 (or as a consequence of): Physician resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Vatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only and manner stated. within 2 To the the 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signa O.C.M.E. May 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARON Lecke MO 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature Day, Year) State MAY 1 7 2004 Registrar

			State of Maryland	/ Department of Health and M	lental Hygier	e2004 15604
			Registrar	Certificate of Death	Reg. I	10.
	Physici	an	1. Decedent's Name (First, Middle, Last)  ROOSEVELT	GALE	Month E	Day Year 3. Time of Death 3.135 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Delath
	LAdiiiii	ICI	Bon Secours Hospita	1 Baltimore		NIA
	Funeral		5. Social Security Number 6. Sex 7. Age in yrs. las	Months Days Hours Min	8. Date of Birth Month, Day, Yea	9. Birthplace (State or Foreign Country)
Н	Director		Usual Residence of Decedent	Yrs.	Jan. 2,1	920 South Carolina
	/land			Town or Location		10d. Inside City Limits
	a-fsh	ctor	Maryland NIA B	altimore		1 XYes 2 □ No
	ith the	Dire	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show rmust be notiliad at	rall	2570 W. Baltimore S	st. 21223	acifu Vac an Na	14. Race - American Indian,
	item Item	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
0030	hours after turel", or ite	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐No Specify:		Specify: Black
2	72 ho netur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b.	Kind of Business/Industry
7	within ene. than "	dm	Elementary Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	6	eneral Refractories
2	filed v Hygie other 1		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	
<u> </u>	lid be lental ked o	To Be	Richard Gale TI	Maga	ie Jo	hnson
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print) (SON)	19b. Mailing Address (Street and Number	I Route Number, City	or Town, State, Zip Code)
<b>∑</b>	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene it Health and Mental Hyglene it Health and Mental Hyglene it is not learn and the notified and other traumatic event. It is Modical Examinar must be notified at		Mr. Richard Gale	2422 W. Frankli	n St. B	Balto. Md. 21223
9			20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Removal from State	ce of Disposition (Name of netery, crematory or other place)	ate 20c.	Location - City or Town, State
altimo	Pa ant ury		`4 □Donation 5 □ Other (Specify)	t. Auburn	2004 W	estport, Na.
a D	permit. Departr Importe eny inje		21. Signature of Funeral Service Licensee	22. Name and Address of Facility  JOSEPH L.  ZZZZ W North Aug	Tuneral 1	Home 3 1311
100			23a. Part I Enter the 11 ease, or complications that cau ed the death. shoo, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate
	Physician		The state of the s	313		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a conseque		5 100-1	4 DAYS
	Examiner		Sequentially list conditions, b. METAST	ATIC CARCINOMA	of PRO	STRATE UNKNOWN
	pe tis	iner		osclerotic HEA		
	xecut and al-tran	Examine	that initiated events c. Due to (or as a conseque	nce of):	E DI	STASE
8/60	icate be executed physician and s the burial-transit	dical E	d			
٥	tificat ng phy as th	a)				
X Q	that the death certifis ed by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d	eath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	the at	/slci	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	th 5 Other (specify)		WORLD Day 10al
7.	that the ed by detac	, Ph	Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death?
Hecords,	w requires that the been signed by th should be detache	d by	- CEREBRO - VASCULA.	R DISEASE	1 🗆 Yes	2 No 3 Probably 4 ØUnknown
Ö		Completed	- CEREBRO - VASCULA - HYPERTENTION		24a. Was an	24b. Were autopsy findings available
ř	0 4 9	THO:			autopsy performed?	prior to completion of cause of death?
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?		(Check only one)	
010	Physician: this certific ral director,	ဥ	1 ☐ Yes 24 No Hospital: 1 ★ Inpatient 2 ☐ EF			
Z C	tending Phys death. for: After this the funeral dir	lon:	1  Natural 5  Pending (Month, Day Year)	8b. Time of linjury at Work?  M 1 Yes 2 No	28d. Describe how in	ury occurred
DIVISION	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At hom		28f. Location (Street	and Number or Rural Route Number,
2	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification;	4 Homicide determined building, etc. (Specify)	-,,,,	City or Town, Sta	ite)
1	pspits hours unerel ly fille	salc	29a. Certifier 1 Certifying Physicien: To the best of my knowl			
2	in 24 the Fu the Fu	ledical	one) and manner stated.			' '
	To To Com	Σ	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month, Day, Year)
	,		- 800000 ×	1D, D 23300	1200 B = 10	MAY 14 2604
	H		30. Name and address of person who completed cause of death (Item 2 SUDHIR. D. PATEL.  31. Date filed (Month, Day, Year)  MAY 1 7 200	2002 W. BA1IU	ST. BA	-1 TO MAD - 21223
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	9 A Anna Val		and the contract of
	Regist	rar	MAY 1 7 2004	L bereion		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 U 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 5:55 PM OHN .E. GROTE MAY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMERE lowson GILLCREST HOSPICE Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Hours 10-M 20 F Months Days Director 214-38-0715 Usual Residence of Decedent ited within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at BALTIMERE 1 Yes 2 No Completed by Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 U.S.A 5506 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 5 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12+6 Westing House CORP MATERIALIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 10HD . O. Grace GROTE LAYFELD Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD, BAlto MO P 5506 FORCE GrOTE GAIL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5/15/04 #☐Burial 2 ☐ Cremation 3 ☐ Removal from State 0 PARKWOOD cem 4 □ Donation 5 □ Other (Specify) injury 22. Name and Address of Facility
HARTLEY MillEr STELLA FURERAL HOME CHTD.
17527 harred RS Balto, MS 21834 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. the diate Cause (Final disease or condition resulting in death) Colon **Physician** Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Medical Certification; To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate bases IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 > ther (Specify) V OS PICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 400

32. Registrar's Signature

N. Charles It Baltimore MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

touon J. Chales

31. Date filed (Month, Day, Year)

		1 - State Registrar  1. Decedent's Name (First, Middle, La	_			rtment of tificate of				Reg. No. 2	004	- 1000
Physici /Medic		EVELYN AILEEN GR							Month MAY	_	2004°	3. Time of Death 8:37 P M
Examin		4a. Facility Name (If not institution, giv GILCHRIST CENTER		ber)		4b. City, Town, TOWS		of Death			nty of Deatl	
Funeral Director		5. Social Security Number 6. S 216~05~4709	6ex  □M <b>X</b> (X) F	. Age (In yrs. las	t birthday) Yrs.	If Under 1 Yea Months Days		Min.	Date of Birt (Month, Date)	, 1918		nplace (State or Foreign untry) yland
death with the Maryland ma 23a or 28a-f ahow rmust be notitied at	tor	10a. State 10b. County Maryland Baltimo	re		Town or Lo	ation	ıntv					10d. Inside City Limits 1 ☐ Yes XX No
ith the or 28a	Director	10e. Street and Number			-	10f. Zip Code				10g. Citizen	of What Co	untry?
ath w		5810 Westwood Ave					21206			USA		
5 # E	by Funerai	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Deced Armed Forc 1 Yes X If Yes, Give Year or Dat	es? No		Vas Decedent of Yes, specify Cu ☐ Yes 2 No			fy Yes or No- can, etc.)	Spec	lack, White	ncan Indian, o, etc. nite
21215-0036 dwithin 72 hours at giene.	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed) College (1-4		16a. Deced (Give ) life. D	ent's Usual Occu kind of work done O NOT use retir	upation e during mos ed)	t of working		16b. Kind of	Business/I	ndustry
led will young the truth		12 yrs.	N/A		Flo	rist						ed~Owner
Maryland d 2 should be file th and Mental Hy if is marked oth traumatic avent	To Be	17. Father's Name (First, Middle, Last, Joseph A. Reinha	rdt				Ai:	leen 1	yler	Maiden Sum		
Mai d 2 st ith and 27 ts n traun		19a. Informant's Name/Relationship (  Owen F. Grammer		,		Address (Stree						
s 1 ar f Hea itam other		20a. Method of Disposition		20b. Plac	e of Dispos	Westwoo ation (Name of atory or other pla	and Aver	Dat		20c. Location		
Baltimore, permit. Pages 1 ar Depertment of Hea Important: If Item, any injury or other page.		A □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2)  21. Signature of Funeral Service Lice			kwood	Cemeter	y 5	5-17-2		Baltin	nore,	Md.
Deperm Perm Perm Perm Perm Perm Perm Perm P			socke		72	Name and Addr assahn Ol Bela	Funera	il Hom Balt	e imore	Maryl	and 2	11236
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cau	used the death.	Do not ente	r the mode of dy					.drid E	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or	r as a conseque	nce of):	-						4622
l betr	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a conseque	nce of):							
P.O. Box 68768, that the death certificate be executed ed by the attending physician and deteched for use as the burial-transit	icai Exa	that initiated events resulting in death) Last	Due to (or	r as a conseque	nce of):							
OX 68	/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnanc	v					024.5	Nata -4 d-15	
.O. Bc the death y the atter	nysiciar	in the past 12 months?  1  Yes 2  Ao 9  Unknowh		th 2 ☐ Fetal de nt at time of deam n		Ectopic pregnant Other (specify) _	су				Date of deliver of the order of	Day Year
0 8 8 0	Completed by Physician/Med	Part II. Dther significant conditions of Schemic hear			ng in the un	derlying cause g	iven in Part I.			bacco use co		the cause of death?
Vital Record stelan: The law requir scartificate has been sl lirector, page 2 should	omplet								24a. Was a autop:	sy med?	prior to co death?	opsy findings available ompletion of cause of
/ital	Be C	25. Was case referred to medical examiner?					26. Place	of Death (	1 Yes		1 🗆 Yes	2   No
Of V Physic this co	2	1 Yes No	Hospital: 1 ☐ Inp		VOutpatient	3L DOA			5 Resid		ther (Speci	th hospice
Division of Vital to Attanding Physician: 1 after death. Diractor: After this certifical tin by the funeral director, p.	ation	Natural 5 Pending 2 Accident investigation		Day Year)	3b. Time of Injury	M 1 [	ork? ]Yes 2.∏t		J. Describe h	ow injury occi	urred	
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of	f Injury - At home , etc. (Specify)	e, farm, stre	et, factory, office		281	. Location (S City or Town	treet and Nun n, State)	nber or Rur	al Route Number,
Di ne Hospital or n 24 hours afte ne Funeral Dir bletely filled in	Medical	29a. Certifier Check only 2 Medical Examone)	nysician: To the b niner: On the bas and manne	is of examination	edge, death n and/or inv	occurred at the testigation, in my	ime, date and opinion, deat	d place, and th occurred	d due to the c at the time, d	ause(s) and r late and place	manner as :	stated. to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	lus			29c. Licen	se number	03	2	9d. Date sign	ed (Month,	Day, Year)
12		30. Name and address of person who	completed cause	of death (Item 2:	3a) (Type, F	rint) Cha	des !	STY	3alto	rone	MO	21204
173.5	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatur	θ		,		-//			

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth

			Certificate of Death Reg. No. 2004 156	0
	Di vivi		1. Decedent's Name (First, Middle, Last)  2. Date of Deeth Month Dey Year	h
	Physici /Medi		CARRIE A GROSS 5 12 04 11:00	All
7	Examir		4a Fecility Neme (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
			Future Care Charles Village Battimore City N/A	
	Funeral Director		5. Social Security Number  218-03-8340  6. Sex  1 M 2X F  91  7. Age (In yrs. last birthday)  Yrs.  7. Age (In yrs. last birthday)  Yrs.  7. Age (In yrs. last birthday)  Yrs.  9. Birthplace (State or For Country)  Calvert Co	əign , M
	/lend		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin	nits
	Mar	ģ	Md. N/A Baltimore	No
	or 28	Funeral Director	10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?	
	th wi	] le	1501 N. Dukeland St. 21216 USA	
	dea L	ine.	11. Maritel Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Haath and Mantel Hyglena. Important: If item 27 is marked other than "natural; or items 23e or 28e-f show important: If item 27 is marked other than "natural; or items 23e or 28e-f show any highly or other traumatic event, the Madical Examinet must be profiled at ance.	by	If Yes, Give 1 1 □ Yes 2/ΔNo Specify: Specify: Black  Year or Dates:	
5	72 h	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)	
짇	vithin Para	Be Completed	Elementery/Secondary (0-12) College (1-4or 5+)	
2	led v	ပိ	12 Homemaker Homemaker  17. Fether's Neme (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
an	d d d d d d d d d d d d d d d d d d d	Be	Dovid Howard	
<u> </u>	should be filed within nd Mantel Hygiena. marked other than umatic event, tre M	70	David Howard Marlba Howard  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Ž	and 2 saith ar		Charleston Y. Watkins (D) 4614 Reisterstown Rd, Baltimore, Md. 21215	
ā,	f Haa		20a. Method of Disposition 20b. Place of Disposition (Name of Capacitor), or other place.	
Ë	Pages nent of int: If its iry or o		1 Burial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify)  Mt. Zion Cemetery 5-18-04 Lansdrowne, Md.	
Baltimore, Maryland	Departm Importa any inju		21. Signature of Funeral Service Licensee  Llovd Ma Estep  22. Name and Address of Facility Estep Brothers Funeral Ser, P.A.	
	40 F # 9		1300 Eutaw Place, Baltimore, Md. 21215	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line.  Approximate Interval Between Onset and Death	
)	Physician /Medical		Immediate Cause (Final disease or condition Cast -intestine bleedy	
1.	Examiner		resulting in death) a.	
	p #	iner	Due to (or as a consequence of):	
2	death certificata ba executed the attending physician and ad for usa as the burial-transit	edical Examiner	Sequentially list conditions, if env. leading to immediate	
68760,	sician buria	al E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
687	ificata g phy: as the	g	resulting in death) Last  Due to (or as a consequence of):	
Вох		M/UE	d	
	deat	Physician/	Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobecco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	ith?
P.O.	et tha d by th atach	Ph	School School Sinda 1- Yee 21 No 3- Probably 4- Unkr	own
	igne bed	Ď		
of Vital Records,	The law requiras thet tha death cel ata has been signed by the attendir paga 2 should be datached for usa	Completed	24a. Was an autopsy performed? 24b. Were autopsy finding aveilable prior to completion of cause	js
Rec	E 8 S	du	of death?	
a	רד: ר ficata זי, pa			
⋚	Physician: r this certific aral director,	o Be	25. Place of Death (Check only one)  examiner?  1   Yes 2   Shoo   Hospitel: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)	
ō	Phy eral d	-	27. Manner of Deeth 28e. Date of trijury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
<u> </u>	Attending ir deeth. actor: Afte by the fune	atio	1 Month, Day Year) tnjury Work? / 2 Accident investigation M 1 Yes 2 No	
	To the Hospital or Attending Physician: The is within 24 hours eltar deeth.  To the Fuere! Director: After this certificata ha complately filled in by the funeral director, paga	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
7	spital	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.	
	To the Hospital within 24 hours of To the Funerel complately filled	edlcai	(Check only one)  2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.	
	To To	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Yeer)	
	0		10 News and address of the completed course of death (first 2002) Time Point	
	"		30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print 4.31 MARY(AN) AVE, BARTIMUTE MILZIS  AMBACHEN WERLETH MI)	28
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	
	Registi	ar	MAY 1 7 2004 Leven & Sparke	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death GOLDMAN Month Day Yeer KENNIE 6:45 A M 2004 05 10 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. Ite Madical Examiner must be notified at once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Funeral** Director

**Physician** /Medical Examiner

signed by the attending physician and dbe detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerat Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be

Division of Vital Records, P.O. Box 68760,

	Good SAMAR	Α.	46. City, Town, or Location of E BALTIMORE	, MD	4c. County of Deeth	
60	5. Social Security Number  5. Social Security Number  6. Security Number  1. Security	7. Age (la vrs. las	st birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Pale of Birth	9. Birthplac Country	(State or For
tor	10a. State 10b. County	10c. City,	Town or Location		Tod	Inside City Lin
ral Director	10e. Street and Number 2425 E. Pres	Ston Stree	101. Zip Code 1 2/2/3	10g. C	Citizen of What Country	?
d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F  1 ☐ Yes 2 ☐ Yo Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Rece - American Black, White, etc	Indian,
Completed	15. Decedent's Ed (Specify only highest grad Elementary Sectingary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  ON STAU CHOO	working 16b.	Kind of Business/Indus	G
To Be (	17. Father's Name (First, Middle, Last)  MarSW 1 Go 19a Informant's Name/Relationship (7	old Man	18. Mother's	Name (First, Middle, Maide	en Sumame) SON or Town, State, Zip Co	oda)
	Seman M. Go  20a. Method of Disposition  Burial 2 Cremation 3	Idraw (Wife)	2425 E. Presto to of Disposition (Name of letery, crematory or orney place)	Street, 7	Location - City or Town	1/2/3
	21. Signature of Funeral Service Licens	MI	P2AName at Address of Falling	114/04 B	Atinon 1	W)
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediete Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line.  Decompus  Due to (or as a donsequer		diac or respiratory arrest,	Ini	proximate lerval Between nset and Death
al Examiner	Sequentially list conditions, if any hading to incrediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.				
Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery Month Da	y Year
þ	SEPSI	<u>S</u>	ng in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the c	ause of death?
Completed	RENAL	INSUFFICI	ency	24a. Was an autopsy performed?	24b. Were autopsy prior to comple death?	etion of cause of
ပိ ြ			On	Death Check on one)		
Be	25. Was case referred to medical examiner?	Hospital:		g Home 5 🖰 Residence	6 ☐Other (Specify)	
To Be	examiner?  1  Yes 2 No   27. Manner of Death Natural 5  Pending 2  Accident investigation	1 patient 2 ER	VOutpatient   3   DOA   Curier   4   Nursing     Nursing   Nursing   28c. Injury at   Work?     Nursing   Nursing   Nursing   Nursing   Nursing     Nursing   Nursin	28d. Describe how inju		
o Be	examiner? 1   Yes 2   No   1  27. Manner of Death   Natural 5   Pending	28a. Date of Injury 28	bb. Time of Injury M 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how inju	ury occurred  and Number or Rural Ro	oute Number,
To Be	examiner?  1 Yes 2 No 1  27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined  2 Homicide Certifying Phy	28a. Place of Injury (Month, Day Year)  28e. Place of Injury - At home building, etc. (Specify)	bb. Time of Injury M 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injuted as a contract of the cause of t	and Number or Rural Role)	4

State Registrar packs

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per Verb., 331,05/15 (24fbb Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 228 PM oraves ea01 2004 May 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore 7. Age (In yrs. Jas Johns Hookins he If Under 1 Year | If Under 24 Hrs. 8.
Months Days Hours Min. 5, Social Security Number [ast birthday] Birthplece (State or Foreign
 Gountry) 6. Sex Date of Birth **Funeral** -78-53 1**5** M 2□ F Director Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner round be notified at 1 (es 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2X No 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Yes Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 is marked other than College (1-4or 5+) (First. Middle. (First, Middle, Last) Be 19b. Mailing Address (Stre r, City or To (to M) 20c. Location Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee al once. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition COTONAY **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner E aquamitatly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by Partill. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No Dertensión 2□ No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 ER/Outpatient Medical Certification: To 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar 31. Date filed (*Month, Day, Year*)

MAY 1 5 2004

Gail

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. The Johns Hopkins Hospital 600 N Wolf Bulto, MDZ1887
32. Registrar's Signature & Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 8845 /-18-05 vt
State of Marytand / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:109 05 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore County of Death Examiner If Under 1 Year | If Under 24 Hrs. Nov. 13, 7. Age (In yrs. last birthday) Yrs. **Funeral** 6. Sex Days 12 M 2 F Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Event and the public of any once. Db. County 10c. City, Town or Location 10d. Inside City Limits Knotimore 1 Yes 2 No Director The 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2122 U.S.A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 Poivorced 15. Decedent's Education (Specify only highest grade completed) 16al Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retire!) 16b. Kind of Business/Industry Element (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) (First, Middle, Maiden Surname, Be MI 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
300 DIShop Aw Baltmore Hd 212 19 Informant's Name/Relationship (Type, anus San Place of Disposition (Name of cemetery, crematory) or other 20a Method of Disposition Date or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation | 5 12 Other (Specify) remsto 21. Signature of Fineral Pervice Licens 22. Name and Address 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VENTRICULAR AUAH YTHM IA MINUTES /Medical Due to (or as a consequence of): Examiner COLON ARY ANTERY DISTASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit H 16-H YEARS BLOOD PAESSINE Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Year Day 5 Other (specify) P.O. | 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by END SMIE ICIONEY DISEASE 3 Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 1 Yes 2 No 1 Yes Hospitel or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral ( 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 24 hours after deat Funeref Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13th MAY 0 29296 2004 secoul on 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOWDER 1406 8 CRAIN HIGHWAY GEN BUNNIE, MD GENARD 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2004 Registrar 1

			1 - For State Registrar	State of Ma		Depa		of H	ealth a		-	_		156LL
	Physici	an	Decedent's Name (First, Middle, Last,	)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic			DREW	HE	EVES					MAY		004	6:30 A. M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,		Location o	f Death			ty of Death	-
			1631 MUSSULA ROAD  5. Social Security Number 6. Sec	7 Age	(In yrs. last bi	rthday)	If Under	TOW:	SOIV	24 Hrs.	8. Date of Birt		TIMORI	
k	Funeral Director			M 2□F	68	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 12/7/19	y, <sub>Year)</sub> 935		place (State or Foreign htry) YLAND
	yland		10a. State 10b. County		10c. City, Tov								1	0d. Inside City Limits
	Mar B-f	io	MD BALTIM	ORE	TC	WSO	N							1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cour	ntry?
	23a (23a)		1631 MUSSULA ROA	D				212	86			USA		
5-0036	be filed within 72 hours after death with the Manyland tal Hygiene. id other than "naturel", or items 23a or 28a-f ehow event, tre Medical Fratt are must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1X Yes 2 N If Yes, Give Year or Dates:	lo		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bl Spec	ace - Americ ack, White, ify:	
)	72 ho vatur	ted	15. Decedent's Edu (Specify only highest grad	cation	16a	. Dece	dent's Usua	l Occupa	ation	of worki	na	16b. Kind of	Business/In	dustry
2121	d within 3 giene. or then "r	Completed	Elementary/Secondary (0-12)  12TH GRADE	College (1-4or 5	+) F		CE OF					LAW ENFO	RCEME	NT
Maryland 2121	d ia b	To Be (	17. Father's Name (First, Middle, Last)  ANDREW HEVESY								(First, Middle, CHNEIDER		rme)	
	od 2 27 is		19a. Informant's Name/Relationship (Ty	rpe, Print) WTF	1		ng Address MUSS				I Route Numbe		_	Code)
Baltimore,	permit. Pages 1 a Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)		20b. Place of comete GARDEN	ry, crei	matory or of	her place	EM.	5/17	7/04	20c. Location PARKVI		
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Licens	olena	<u> </u>						JOHNSO VD. TOW			ME, P.A.
	Physician /Medical		23a. Pa 1. Enter the disea or complished, or heart failurs. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each lin	the death. Do	not ent	ter the mode	of dying	g, such as	cardiac o	r respiratory ar	TIV	$\epsilon$	Approximate Interval Between Onset and Death
3760,	ate be executed with the burial-transit he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):								
P.O. Box 68	The law requires that the death certifical ate has been signed by the attending phy page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pro						ate of delive	ery Day Year
	w requires that been signed b should be deta	ed by Pr	Part II. Other significant conditions col		ut not resulting				in in Part I.	SE	23e. Did to			ne cause of death?
Vital Records,	The law re ate has bee bage 2 sho	omplet									24a. Was autop perior 1  Yes	an 24b esy rmed? 254No	Were auto prior to coo death?	psy findings available impletion of cause of
112	ian: artifica ctor,	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
	hysic lidire	20	1 Yes No	Hospital: 1 🗌 Inpatie	nt 2 ER/O	utpatier	nt 3 🗆 🗅 🗅 🗅	A Othe	ar: 4 □ Nu	rsing Ho	ne 5 Resid	dence 6 🗆 Ot	her (Specif	y)
Division of	Attending Physician: r death. ector: After this certific. by the funeral director, i	ation:	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	Year) 28b.	Time o Injury	f 2:	3c. Injury Work 1 🗆 1	at ? /es 2 □ i		28d. Describe h	now injury occu	irred	
Divis	s after de s Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, f c. (Specify)	arm, str	reet, factory	, office			28f. Location (S City or Tow	Street and Num m, State)	ber or Rura	l Route Number,
/	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier Check only one) Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination at	e, deat nd/or in	h occurred a vestigation,	at the tim in my op	e, date an	d place, a	and due to the o ed at the time, o	cause(s) and m date and place	nanner as si , and due to	ated. the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	M					number	4		29d. Date sign	ed (Month,	Day, Year)
	1. (		Broan	0000			7	>41	549	4		5/13	104	
	741		30. Name and address of person who co		eath (Item 23a)			ui te	320	To	wson, M	D 2128	36	
	Sta Registi		31. Date filed (Month, Day, Year) 004	32. Registra	ar's Signature	2000								

		1	For State Registrar	State of M	aryland	•	artment of H		i Mental Hy	giene Reg. No. 200	4 15612
	Physicia	an	Decedent's Name (First, Middle, Las	EMORY	R.	HUL	L		2. Date of Dea Month MAY		3. Time of Death 5:00 A. M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number,	)		4b. City, Town, o	Location of De		4c. County of E	
	Funeral Director		5. Social Security Number 6. Se		ge (In yrs. las: 72	t birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birt in. (Month, Da 02-25-	th y, Ye <i>ar)</i> 1932	Birthplace (State or Foreign Country) MARYLAND
	aryland ahow		Usual Residence of Decedent  10a. State 10b. County  MD. CECIL		10c. City, T		ARLESTOWN				10d. Inside City Limits 1 ☐ Yes 2 XXII
	with the M a or 28a-f be notifie	<u></u>	10e. Street and Number 124 CONESTOGA	STREET		011	10f. Zip Code	21914		10g. Citizen of Wha	t Country?
ဖွ	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or Items 23a or 28a-f ahow event, I've Medical Exatrinat must be notified at	Ξ	11. Marital Status 1 □ Never Married 240 Married	12. Was Decedent Armed Forces 1 Wes 2 In Yes, Give	?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 <b>XX</b> No		(Specify Yes or No erto Rican, etc.)		American Indian, White, etc. WHITE
21215-0036	in 72 hours n "natural", Audicul Exz	Completed by	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra	Year or Dates: ucation	KOKE	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation	working	16b. Kind of Busin	
	2 should be filed within and Mental Hygiene. is marked othar than "aumatic event, the Med	Be	17. Father's Name (First, Middle, Last)  GEORGE E	4 YEARS	34)		SALESMAN	18. Mother's i	Name (First, Middle,		REBUILDING
Maryland	2 should and Mer ia marke aumatic	ပို	19a. Informant's Name/Relationship (7 EMORY H. HULL					and Number or	Rural Route Numbe	er, City or Town, Sta	
Baltimore,	0 0		20a. Method of Disposition  **Burial 2	Removal from State	20b. Plac	e of Disponentery, cre	osition (Name of matory or other place DGE CEME	ce)	Date	20c. Location - City	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	5		R		ON FUNE	RAL HOME,	INC. TOWSO	YORK ROAD ON.MD.,21204
	Pnysician		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PNEU	HONLA		ter the mode of dyir	ng, such as care	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death DAYS
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate gauge Enter Underlying	LEREB	s a conseque Solvery Asconseque	LUAR	015645	£			Months
60	cate be executed oblysician and the burial-transit	il Examiner	Cause (Disease or injury that initiated events resulting in death) Last		s a conseque		Nout at	BRAIN			T MONTHS
Box 687	law requires that the death certificate as been signed by the attending physion 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom  1 Live birth  4 Pregnant	2 🗌 Fetal d	eath 3	□Ectopic pregnanc □ Other (specify)	y		23d. Date o Month	f delivery Day Year
ds, P.O.	w requires that I s been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death	but not result	ing in the u	underlying cause gr	ven in Part I.	23e. Did t		te to the cause of death?  Probably 4 □Unknown
of Vital Records,	iician: The law rec certificate has bee rector, page 2 shou	Completed							24a. Was auto perfo 1 Yes	psy prio primed? dea	re autopsy findings available r to completion of cause of th? Yes 2 PNo
Vita	Phyaician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 WNo	Hospital: 1 ☐ Inpa	tient 2∏EI	R/Outpatie	nt 3□ DOA Oth		Death (Check only on Home	one) dence 6 □Other (	Specify)
ion of	ng fter ne	ation; To	27. Manner of Death  11. Natural 5 Pending investigation	28a. Date of In (Month, D		8b. Time o Injury	of 28c. inju Wo	ry at		how injury occurred	
Division	To tha Hospital or Attandii within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Certification;	3 Suicide 6 Could not b 4 Homicide determined	building,	etc. (Specify)		reet, factory, office		City or To	wn, State)	or Rural Route Number,
	tha Hospi hin 24 hou the Funar mpletely fil	Medical	29a. Certifier (Check only one)  2 Medical Example of Certifier	ysician: To the bes niner: On the basis and manner:	of examinatio	iedge, dea on and/or in	th occurred at the tinvestigation, in my		ace, and due to the occurred at the time,	cause(s) and manne date and place, and 29d. Date signed (A	due to the cause(s)
	5 1 K 2 8	_	Signature and the or serimin					וורדוי			2004
	31		30. Name and address of person who DANID GAR-EL	completed cause of			11	3 ELK	TON MAR	E DHATE	1921
e	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu		to ha	(i)			

			_ ror	Maryland			ealth and M	lental Hyg	giene		
		4	= State Registrar		Cen	tificate of L	Death		Reg. No. 2	104	15613
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last)	offr	nan	n		Month Cy	Dav	Year SO4	5. IS GWM
	Examin		4a. Facility Name (If not institution, give street and numb	er)			Location of Death		4c County	of Death	<b>1</b> 4
	Funeral Director			Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt NOV. 16	1914	9. Birthola	ace (State or Foreign
	ס		Usual Residence of Decedent		Town or Loc	ation					Od. Inside City Limits
	Aarylar I show	ō	10a. State 10b. County Maryland Baltimore		Towson					10	1 Tes 2 No
	the h	Director	10e. Street and Number		10030	10f. Zip Code			10g. Citizen of V	What Count	Iry?
	th with	ai Di	409 Virginia Avenue Ap	t. 218		21286	5		USA		
	r dea	Funeral	11. Marital Status 12. Was Decede Armed Force	§?	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - America ck, White, e	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel; or Iteme 23e or 28e-f show event, the Medical Examiter count by notified at	by Fu	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date		1	☐ Yes 2X No	Specify:		Specify	~ Whit	:e
2-00	72 houndere	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	ent's Usual Occupa	ation during most of work	ing	16b. Kind of Bu	usiness/Ind	ustry
121	within ane. then	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)		nstress	)		Cloth	ina	
<b>d</b> 2	Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)		Jean	113 01 033	18. Mother's Name	(First, Middle,			
/lan	Mental Mental srked stic ev	To B	Charles Vesely				Mary		Korecky	<u>'</u>	
Aan	2 sho	) je	19a. Informant's Name/Relationship (Type, Print)				and Number or Run				Code)
e,	1 and Health em 27 ther t		Genevieve Cozzubo / Niece  20a. Method of Disposition	20b. Pla	ce of Dispos	ark Ave.		Mary lar	10 Z1ZU4 20c. Location -		wn, State
חסר	ages ant of l it: If it	1	1 Burial 2 Cremation 3 Removal from St  4 Donation 5 Other (Specify)	100	-	atory`or other place Forest. C	em. 5/18,	/04	Owings	Mills	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or iteme 23a or 28a-f show eny Injury or other traumatic event, the Madical Examilian countries of the profiled at once.		21. Signature of Fune at Service Lice see	M	22.	Name and Address		-	10	50 Yo	rk Road
			23a. Part1. Enter the disease, or complications that a shock, or heart failure. List only one cause of actions that the shock of the sh	sed the death.			g, such as cardiac				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ctati		Esoph	ureal	Carci	noma		Onset and Death
	/Medical Examiner		resulting in death)	as a conseque	ence of):	1	1				
M.	Lxammer	100	Sequentially list conditions, if any leading to immediate	as a conseque	ence of):						
A	ansit	Examiner	dray, leading to immediate cause. Enter Underlying cause, Unisate of injury that initiated events cause.								
75	be wanted cian and burial-transit	Еха	resulting in death) Last Due to (or	as a conseque	ence of):						
2. 68.	हैं हैं	dicai	d								
004 ox 6	vding se as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes						23d. Da	te of deliver	ry
200.	atte	by Physician/Me	in the past 12 months?  1 ☐ Yes 2 🗷 No	h 2 ∏ Fetal d nt at time of dea		Ectopic pregnancy Other (specify)			Мо	enth (	Day Year
14, P.0	t the by th tache	Phys	9 Unknown  Part II. Other significant conditions contributing to dea		ting in the up	dorhing cauca cau	an in Part I	23e Did to	shacco usa cont	ribute to the	e cause of death?
y s	sicien: The law requires the certificate has been signed rector, page 2 should be de	d by	Part II. Other significant conditions contributing to dea	in out not result	ung in the un	denying cause givi	on in r and r.		′es 2 □ No		abiy 4 🗆 Unknown
FEMANN MA.	law requals been 2 shou	Completed						24a. Was		Were autop	osy findings available
1 Re	The It	Com						perfo	med?	death?	•
HOFFMANN of Vital Re	Physicien: this certific	Be	25. Was case referred to medical examiner?			all post Othi	26. Place of Deat				
HOF of	Phys r this ral dir	); To	27. Manner of Death 28a. Date of	Injury 2	R/Outpatient 28b. Time of	28c. Injun	v at		lence 6 □Oth now injury occur		)
	Attending r death. ector: After by the fune	atlor	1 ☑Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year)	Injury	M 1	k? Yes 2 ☐ No				
MARGARET Division	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	Injury - At hom , etc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
MAR	Hospital     24 hours a     Funeral C letely filled		29a. Certifier 1 △ Certifying Physician: To the b								
·	the Ho hin 24 h the Fu npletely	Medical	(Check only 2 Medical Examiner: On the bas and manner		on and/or inv						
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	LIA		29c. Licens	2 ) 4 i	)	29d. Date signe	(Month, C	ray, rear)
	1.		30. Name and address of person who completed cause	of death (Item	23a) (Type 1	Print)	/ ( )		110	1 /	COO
	0		ERNESTINE WRIGHT, M.D.	1		Y VALLEY	ROAD TI	MONIUM,	MD 2109	93	
		ate	31. Date filed (Month, Day, Year) 32. Re-	gistrar's Signatu			. 3 -				
	Regist	ar	MAY 1 7 200	STEEN	G. 13	Speak	1				

			1 - For State Registrar	State of	Marylar		artment rtificate					Reg. No	e 200	14	1561	1.
Ī	Physici		1. Decedent's Name (First, Middle Mildred B. Hart	e, Last)							2. Date of D Month May 12	eath 200	Ď4	ear	3.1 Time of Deal	h M
	/Medic Examin		4a. Facility Name (If not institution Stella Maris Hospic		ber)		4b. City, T		Location of	of Death		40	: County of D Baltir	nore		
L	Funeral Director		5. Social Security Number 220–03–8468  Usual Residence of Decedent	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, 1) March 3	inth Pay, 1917 • 1917	7 OH	Birthpla Countr 110	ce (State or Ford y)	∍ign 
	Maryland	tor	10a. State 10b. County	imore	10c. Cit	ty, Town or Lo Spark								100	d. Inside City Lin	
	h with the 23a or 28s	al Direc	10e. Street and Number 701 Indian Spring	Court			10f. Zip (	Code 1152					itizen of Wha SA	t Countr	y?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar out the notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	12. Was Deced Armed Ford ied 1 Tyes 2 If Yes, Give Year or Dat	ces?		Was Decedent Yes, special Yes 2	ify Cuba	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V Specify:	White, et	c.	
Maryland 21215-0036	within 72 ho iene. than "natur ibe Medical.	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)		4or 5+)	(Give	dent's Usual kind of word DO NOT usi nemaker	k done a	turina mos	t of work	ing		Gind of Busin	ess/Indu	stry	
/land 2	uld be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Zachary C. Kurko	Last)						er's Name tine 7	∍ (First, Middl 「ruz	e, Maider	n Surname)			
	and 2 sho ealth and I m 27 is me		19a. Informant's Name/Relations Patricia B. Bennet		000		dian S	ring		Spa	al Route Num arks Mar Date	yland	21152			
Baltimore,	it. Pages 1 rtment of H rtant: If ite njury or ot		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service	pecify)	tate	cemetery, crei	natory or ot	her place	·	- /1 4	101		ocation - Cit timore 1			
Ba	permi Depa Impo any is		23a. Part1. Enter the disease, or	e L. H	Uto	Lawn Ce Hilton 22 th. Do not ent	eonard 305 Hai	J. R	uck, I Road	inc. Balt	cimore M	arylar	nd 212	14	Approximate	
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aBONI Due to (c	E METS or as a consec	quence of):		, , , , ,	,						nterval Between Onset and Death	
376 <b>0</b> ,	ate be executed hysician and he burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	SMET/	ASTATI(	CARCI	NOMA							P.		
.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown		nth 2 ☐ Feta ant at time of c	aldeath 3	Ectopic pre Other (spe						23d. Date of Month		r Pay Year	
s, P	sign d be	by	Part II. Other significant condition	ons contributing to dea	ath but not res	sulting in the u	nderlying ca	use give	en in Part I						cause of death?	
Il Record	The law ate has b page 2 s	Completed	, E								per	s an opsy formed? 2 🙀 No	prior deat	r to comp th?	sy findings available tion of cause	
of Vital	Physician: Th r this certificate aral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospitals		ER/Outpatier		A Othe	er: 4 □ Nu	ırsing Ho	n (Check only me 5□Res 28d. Describe	sidence		Specify)	HOSPICI	E
Division	rr Attending Ph ter death. Irector: After th I by the funeral	ertification:	1 X Natural 5 Pendin 2 Accident investion 3 Suicide 6 Could 4 Homicide determine	gation not be 28e. Place		Injury some, farm, str	М	1 🗆 1	(? Yes 2 ☐			(Street a		or Rural I	Poute Number,	
Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical Cer	29a. Certifier 1X Certifyir (Check only one)	ng Physician: To the li Exeminer: On the ba	sis of examina	owledge, deat ation and/or in	h occurred a	at the tim	ne, date an pinion, dea	id place, ith occurr	and due to the	e cause(s	s) and manne d place, and	er as stat	ted. he cause(s)	
)	To the within? To the comple	Med	29b. Signature and title of certifie				29c.	License	number	25		29d. Da	ate signed (N	_		
_	5		30. Name and address of person  DR. TARIQ MA	HMOOD 230	O DULA	NEY VAI		D.	TIMO	NIUM	, MD 2	1093				
	Sta Regist		31. Date filed (Month, Day, Year)	1 7 2004	gistrer's Sign		Spec	W								
DH	HMH 17 Rev 1/2	001		•												

3:45 а.ш.

MAY 12, 2004

MILDRED HART

			1 - State Registrar		Department of F	lealth and M	lental Hygie Reg.	ne 2004	15615
- 1	Physicia	an	Decedent's Name (First, Middle, Last)		Hall			Day Year	3. Time of Death
	/Medic			ude H.		r Location of Death	ण वस्	4c. County of Death	03:07 AM
	Examin	er	4a. Fecility Name (If not institution, give street and number)	57 1		_		Anne A	and do i
			5. Social Security Number 6. Sex 7. Ag	e (In yrs. last bir	nthday) If Under 1 Year		8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
	Funeral Director		217-22-2443 1□ M ¥□ F		Yrs. Months Days	Hours Min.	(Month, Day, Ye Mar 31, 19	09 Cou	MD
			Usual Residence of Decedent	T					
	anylan	_	10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits 1 ☐ Yes X2 ☐ No
	Ba-f	Director	Maryland Anne Arundel		104 Zin Codo		100	Citizen of What Cou	
	death with the Maryland ma 23a or 28a-f ehow r must be notified at	급	10e. Street and Number 4045 Brummel Road		10f, Zip Code	21122	Tog.	U.S.A	*
	eath must	by Funeral	11 Marital Status 12. Was Decedent	Ever in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Amer	ican Indian,
10	fter d	표	1 Never Married 2 Married 1 Yes 2				Rican, etc.)	Black, White	
~8	ours a	by	3√ Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 21☐ No	Sp <del>в</del> спу:		Specify: B	lack
5-0	ithin 72 hours ie. ien "neturel", i Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of work	ing 16b	o, Kind of Business/lo	ndustry
¥ 12	dthin ne. han	шb	Etementary/Secondary (0-12) College (1-4or	5+)		r Master		George Mea	ide Base
7	be filed within 72 hours after death with the Marylan ital Hygiene. bd other than "natural", or itema 23s or 28s-f ehow event, Ita Mudical Examinational be notified at	ပိ	12 17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Mai	den Sumame)	
and	Mental Merked o	To Be	James Wallace				Saral		
rvde $Ho$ Maryland 21215	ges 1 and 2 should be t of Health and Mental if tem 27 is marked or or other traumatic ev	-	19a. Informant's Name/Relationship (Type, Print)	198	b. Mailing Address (Street				p Code)
-1	and 2 alth a 127 to		Mary Jane McClinton Daughter		4045 Brummel F				
ore	ges 1 and 2 t of Health If Item 27 or other tru		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	an moto	of Disposition (Name of ary, crematory or other place	ce)		. Location - City or T	
in	nit. Pages vartment of I ortant: If th injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	<u></u>	/It Zion Church Ce	2113	5/14/04	Pasadena, N	Maryland
Gert Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee		22. Name and Addre		I Home P.A.		
	40 5 9 Q		23a. Part 1. Enter the disease, or complications that cause	d the death. Do		others Funera taw Place Bal			Approximate
6	Physician /Medical Examiner  per partial-transit  per partial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events	s a consequence	ol):	nonia			Onset and Death
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate the within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the topical death of the funeral director.	Completed by Physician/Medic		e of pregnancy 2 □ Fetal death at time of death	h 3□Ectopic pregnanc 5□ Other (specify)	у		23d. Date of delin Month	very Day Year
ds, P	luires that n signed b	d by P	Part II Other significant conditions contributing to death Advanced Lem	1	in the underlying cause give	ven in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to	the cause of death?  bably 4 Unknown
Division of Vital Records,	The law recte has bee age 2 shoo	omplet	Congestive Hear	t fa	<i>slure</i>		24a. Was an autopsy performed	prior to o death?	opsy findings available ompletion of cause of
tal	an: rtifica tor, p	a)	25. Was case referred to medical			26. Place of Deat	h (Check only one)		
>	nysici iis cei direc	To B	examiner?  1  Yes 2 No Hospital: 1 tnpat	ent 2 ER/O	utpatient 3 DOA	ner: 4 Nursing Ho	me 5□Residenc	e 6 □Other (Spec	ify)
0	ng Pt fter th		27. Manner of eath 28a. Date of Inj 1 Natural 5 ☐ Pending (Month, D.	ury 28b. ay Year)	Time of 28c. Injury Wo	rk?	28d. Describe how	injury occurred	
ivisio	or Attendi ter death. irector; A n by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, fatc. (Specify)	M 1 ☐ arm, street, factory, office	]Yes 2 □No	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
٥	Hospital of the hours at Funeral Diety filled i	edical Ce	29a. Certifier  (Check only   Medicat Examiner: On the basis	of examination ar					
	thin 2 the control	Med	one) and manner s  29b. Signature and title of certifier	iai <del>d</del> u.	29c. Licens	se number	29d.	Date signed (Month	, Day, Year)
	F 3 F 8		Ademta Orhan	jerno	mi) Do	0597	28	05 00	1 2004
			30. Name and address of person who completed cause of	death (Item 23a)	(Type, Print)				
	10		ADEYINKA O. LAIY	EMO	mD NOR	RTH AR	UNDEL	HOSPIT	AL_
	St Regist	ate rar	31. Date liled (Month, Day, Year) 32. Regis	trar's Signature	H. Ana	Min.			

		•	State of Maryland / Department of Health  1- For State Registrer  Certificate of Deat	and Mental Hygiene 2004 15616
	**		Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physicia		Stirley Harrid	Month Day Year 4:03 fm
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locatio	
1	Examin	er	B. R. Elisial Rivers	E City WA
				er 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
ш	Funeral Director		2/2-34-8/15 1 M 2/3 F 67 Yrs. Months Days Hours	ler 24 Hrs. 8. Date of Birth s Min. (Month, Day, Year)  June 16, 1936  9. Birthplace (State or Foreign Country)  Country)  South CARCOLING
			Usual Residence of Decedent	Sque 10,1192 Day Gran
	/land		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Man fied	to	HARYLAND WA BAITIMORE	1 X Yes 2 □ No
	the 288	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	3a o		3522 Edmondrow Ave 21229	USA
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Examiner must be notified at	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Control o	Origin? (Specify Yes or No- 14. Race - American Indian,
(0	or Re	F	Armed Forces? If Yes, specify Cuban, Mexic	
5-0036	urs a	þ	3 ☐ Widowed 4 ☑ Divorced	HYICIAN AMORICAN
9	72 ho	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	16b. Kind of Business/Industry
2	- 20	ple	life DO NOT use retired	10 1 21 410 01
2121	er th	00	Elementary(Secondary (0-12) College (1-4or 5+) School Bus Delver	
밀	be filed within 72 hours after death with the Marylan ital Hygiene. So dother than "natural", or Items 23a or 28a-f show event, It's Madical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)  18. Mo	ther's Name (First, Middle, Maiden Sumame)
<u> a</u>	should be and Mental marked o	6	FERCY GILMER MA	RGARET Dykes
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, ILe M			neer or Rural Route Number, City or Town, State, Zip Code)
			EILEEN MOUZON 3804 Rokely Ros	ad-Baltimore, Manyland 21229
Baltimore,	ges 1 and t of Health if item 27 or other to		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery/crematory or other place)	Pate 20c. Location - City or Town, State
Ĕ	Pages nent of I int: If it		Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)	4/18/04 Albertus MARYAND
Ħ	그 문문을		21. Signature of Funeral Service Licensee 22, Name and Address of Fa	THE FUNERAL SERVICE, MARY AND 9
ä	Depa Impo any ir		Maria, m. Teresare 3405 W. FRA	nklin Street BATHMORE, MARYSING
			232 Part Enter the ticease or complications that caused the death. Do not enter the mode of dying such	as cardiac or respiratory arrest, Approximate Interval Between
			shock or head failure. List only one cause on each line.	Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	DESEATE
н	Examiner		Due to (or as a consequence or).	
		<u>ا</u>	Sequentially list conditions, frank, leading to immediate b. Due to (or as a consequence of):	
177	nsit	Examlner	if any, leading to immediate Due to (or as a consequence of): cause Disease or injury	
	xecu al-tra	Xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal E		
387	phys phys s the	을	d	
9 X	ding Se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
Box	atten for u	lan	in the past 12 mooths?	Month Day Year
0	the de	yslc	1   Yes 2   And 9   Unknown	
Δ.	ires that the death certific signed by the attending p d be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	rt I. 23e. Did tobacco use contribute to the cause of death?
S,	ires t signe			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
or 0	w requir been si should	Completed		2000000 2000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000
ec	law lasb	du		24a. Was an autopsy prior to completion of cause of
Ш	The gate h	Ö		performed? death?  1 Yes 2 No 1 Yes 2 No
/ita	sian: artific	Be	examiner?	ace of Death (Check only one)
7	Physician: this certificand director, it	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	Nursing Home 5 Residence 6 Other (Specify)
0	ng Pl fter tl nera	ü	27. Manner Death 1 atural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Work?	28d. Describe how injury occurred
0,0	# 4 € E	힐	2 Accident investigation M 1 Yes 2	
-07	he or	10		28f. Location (Street and Number or Rural Route Number,
.≥	r Attending ter death. irector: After by the fune	tiflea	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, State)
Division of Vital Records,	ital or Attendi rs after death. al Director; A led in by the fu	Certification;	determined 286. Place of Injury - At nome, farm, street, factory, onice	City or Town, State)
Div	lospital or Attan I hours after dea uneral Director ily filled in by the		4 Homicide  288. Place of mjury Althorne, family, street, factory, office building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	and place, and due to the cause(s) and manner as stated.
Div	the Hospital or Attenin 24 hours after dealin 24 hours after dealine Funeral Director	edical	4 Homicide  28e. Place of mjury At nome, family, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.	and place, and due to the cause(s) and manner as stated.
Div	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		4 Homicide  288. Place of Injury Althorne, family, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (sheck only one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, of and manner stated.  29b. Signature and title of certifier  29c. License number	and place, and due to the cause(s) and manner as stated. seath occurred at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
Div	To the Hospital or Attenwithin 24 hours after dea To the Funeral Director completely filled in by the	edical	4 Homicide  28e. Place of mjury At nome, family, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.	and place, and due to the cause(s) and manner as stated. seath occurred at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
Div	To the Hospital or Atten within 24 hours after dea To the Funeral Director completely filled in by the	edical	4 Homicide  288. Place of mjury Actionne, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only and building)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number building.	and place, and due to the cause(s) and manner as stated. feath occurred at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
Div	To the Hospital or Atten within 24 hours after dea To the Funeral Director completely filled in by the	edical	29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	and place, and due to the cause(s) and manner as stated. feath occurred at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
Div	To the Hospital or Atten within 24 hours after dea Yours after dea To the Funeral Director completely filled in by the	Medical	4 Homicide  288. Place of mjury Actionne, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only and building)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number building.	and place, and due to the cause(s) and manner as stated. feath occurred at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)

			Please	Type or Print in Blac	k Indelible Ink. Ensure A	III Copies A	re Legible.	
		1	For State	State of Maryland / I	Department of Health and I Gertificate of Death		ene2004	15617
			1. Decedent's Name (First, Middle, La	88190 brk fil (831-2/1	//U4 JH	2. Date of Death		3. Time of Death
	Physicia		SAMUEL		IWRY	Month MAY S	Day Year 2004	20:45 PM
>	/Medic Examin		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Deat		4c. County of Deat	h
			SINAL HOSPITAL	OF BALTIMORE	BALTIMORE		N/A	
	Funeral Director		5. Social Security Number 6. S 217-30-3156	7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth Month. Day 12/25/19	(ear) 9. Birt	hplace (State or Foreign untry) POLAND
			Usual Residence of Decedent	Х 30				
	yland		10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
	a-fs	Director	MD N/F	BALTIMO	ORE			1 Ves 2 No
	th that	)re	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	untry?
	th wi	a	2401 BRAMBLETON	ROAD	21209		U.S.A.	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. d other than "naturel", or items 23a or 28a-f show event, the Medical Evantina in ust to motified at event, the Medical Evantina in the motified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Tes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: WH]	o oto
Ö	2 ho	ted	15. Decedent's E (Specify only highest gr		Decedent's Usual Occupation (Give kind of work done during most of wo	rkina	6b. Kind of Business	•
21	thin 7 e. an "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NDT use retired)		JOHNS HOPE	
N	filed with Hygiene. other thai	Con			OFESSOR EMERITUS		UNIVERSITY	
Maryland	be fill tal H	Be	17. Father's Name (First, Middle, Last	)	DEPNA	me (First, Middle, M FDCTFTN	-HEPNER	
Уlа		2	JACOB		IWRY THE			Zin Co do l
lar	S S S		19a. Informant's Name/Relationship	,,,,,	b. Mailing Address <i>(Street and Number or Ri</i> 401 BRAMBLETON RD. B		-	
	C = 0 L		NINA IWRY / WIFE		of Disposition (Name of		Oc. Location - City or	
altimore,	Pages 1 arenent of Heannt of Heannt: If item	1 1	20a. Method of Disposition  1	Removal from State	ery, crematory or other place)			
ţ	. Ра tmen tant: jury		'4 □Donation 5 □ Other (Speci		Control of the Contro	2/2004	BALTIMORE	•
Bal	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Dce	nsee	22. Name and Address of Facility S 8900 REISTERSTOWN		ON & BROS. VILLE, MD	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	replications that caused the death. Do	not enter the mode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Pnysician	ar n	Immediate Cause (Final disease or condition	and the second second	Hemorrhage			Onset and Death
	/Medical		resulting in death)	a Due to (or as a consequence	,			
b	Examiner		O	b				
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Error to carrying Cause (Disease or injury	Due to (or as a consequence	of):			
	cuted nd iransit	amine	that initiated events	c				
0	e axe ian a urial-1	Ĕ	resulting in death) Last	Due to (or as a consequence	• of):			
68760,	ate be	Ca		d				
39	The law requires that the death certificate be axecuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE:					
Вох	th ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat			23d. Date of de Month	livery Day Year
O. E.	e dea the at	sici	1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			
P.O.	d by	Phy		contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	ras th	by	End Stage Re		in the dilatifying educe given in Fact.			robably 4 Minknown
Records,	w requir been si should	eted				<del></del>		
ec	law nasb e 2 sl	nple	Gastric Cuni	jev		24a. Was an autopsy perform	24b. Were at prior to death?	utopsy findings available completion of cause of
		Co					ZNo 1□Yes	
/ita	ysicien: The law is certificate has director, page 2 t	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one		-
of	Physic this o	2	1 Yes 2 No	I I I I I I I I I I I I I I I I I I I		Home 5 Resider		cify)
U C	ing P	lon:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	(Month, Day Year)	. Time of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe no	winjury occurred	
Sio	Attending Physicien: r death. ector: After this certific by the funeral director,	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	1-		28f Location (Str.	eet and Number or R	ural Route Number
Division of Vital	or At after of Direction by	Certification:	4 Homicide determine	building, etc. (Specify)	arm, street, ractory, onice	City or Town,		3747 7741 774
J	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical Ce	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exp	hysician: To the best of my knowledge uniner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and plac und/or investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	thin 2 the thin 2 the mple	Mec	29b. Signature and title of certifier	and mailler stated.	29c. License number	29	d. Date signed (Mon	h, Day, Year)
	T W G		DAMPIALS,	DO	RES-000	1	MAY 8, 20	
	TI		30. Name and address of person who	completed cause of death (Item 23a	) (Type, Print)			
	7		JENNIFER MOI	RAVES, DO SI	NAI HOSPITAL OF	BALTIMOI	25	

Registrar DHMH 17 Rev 1/2001

State

3/ Registrar's Signature

		1	State of Maryland / Department of Health State AMEND TIM: #1 PER PHY G831 5/17/04 Hertificate of Deat.	n and Mer th	ntal Hygien Reg. N	e 200	15618
	\$ 1		1. Decedent's Name (First, Middle, Last) WINFTED JACKSON III	2.	Date of Death		3. Time of Death
	Physicia		Winfield Jackson			year 200	4 1600 M
	/Medic Examin	100	4a. Facility Name (If not institution, give street and rlumber)  4b. City, Town, or Location	on of Death	4	c. County of Dea	h
			Howard County General Columbia			Howard	
	Funeral		Months Days Hours	s Min. 8.	Date of Birth (Month, Day, Yea	9. Bird	hplece (State or Foreign ountry)
****	Director		210-54-7492		9-10-195	00	Md
	and **		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	f sho	ō	Md N/A Balto				1 X Yes 2 ☐ No
	the 28e	rec	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Co	ountry?
	3a or		1000 W. Lafayette Avenue Apt 1 212	217	}	USA	
	hours after death with the Maryland tural, or Items 23a or 28e-1 show at Esaminat must be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic of the Specify Cuban, Mexic	Origin? (Specify	y Yes or No-	14. Race - Ame Black, Whit	
စ	after or ite	T	Never Married 2 Married 1 Yes, Give 1 Yes, 2 No Specific		41, 010.)	Specify:	Black
93	ours iral',	d by	3 Widowed 4 Divorced Year or Dates:				
<u>,</u>	natu crice	lete	15. Decedent's Education (Specify only highest grade completed)  [Specify only highest grade completed]  [Ife, DO NOT use retired]	nost of working		Kind of Business	Industry l Hospital
12	withir ane. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade N/A Computer Syst	tem Admi		i delicia.	Hospital
р 2	filed Hygid Sther				irst, Middle, Maide	en Surname)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event, I'm Medical Estimate must be notified at ance.	To Be	Winfield Norcoss Jackson, Jr Do	oris Mir	nnie Alle	en	
ary	shou nd M mar	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num	nber or Rural R	oute Number, City	or Town, State,	Zip Code)
Ž	alth a alth a 27 is		Ellen A. Morgan - Cousin 7991 Jones Road	Jessup,	Md 2079	94	
Baltimore,	of He of He itam		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c.	Location - City or	Town, State
Ĕ	Page nent ent: If		'4 □ Donation 5 □ Other (Specify) Allen Washington	5-10-20	004 Jes	ssup, Md	
a	rmit. spartr sport sport y inju		21. Signatur of Funeral Service Licensee 22. Name and Address of Far	cility Marc	ch F/H V	Vest	
<u> </u>	20 = 2				enue Balt	o, Md 2	
3			23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock or heart failing. List only one cause on each line.	as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition a. 56915				2 Weeks
	/Medical Examiner		resulting in death)  Due to (of as a consequence of):	0 1.4:0			Elleare
·	The state of	_	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	cuse			7 4000
	ted	nlne	cause. Enter Underlying Cause (Disease or injury  Tupe II Diabetes M.	ellitus	,		15 YERTS
,	axecun and	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physicien and s the burial-transit	dlcal	d				
9	tificat ng ph) as th	led		<del> </del>			
Вох	eath certific attending p	by Physiclan/Me	JF FEMALE:     23c. If yes, outcome of pregnancy       23b. Was decedent pregnant     1 ☐ Live birth     2 ☐ Fetal death     3 ☐ Ectopic pregnancy			23d. Date of de Month	livery Day Year
О	e dea he att	sicl	In the past 12 months?  4 □ Pregnant at time of death 5 □ Other (specify)			WORTH	Day Todi
<u>Р</u>	that the de led by the a detached f	Phy	9 Unknown  Part II, Other significent conditions contributing to death but not resulting in the underlying cause given in Pa	241	23e Did tobacco	n use contribute to	the cause of death?
	Se us es	by	Cere bral Inter 4700	211.1.	1 □ Yes		robably 4 Unknown
Ö	w requir been si should	eted	Aceste myocardial infarction				
Records,	has the general has the	Completed			24a. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
a			Hypertension		1 ☐ Yes 2 💢	No 1 ☐ Yes	2 2 No
Vital		Be c	examiner? Hospital: Other:	lace of Death (C	5 Residence	€ □Othor (Con	10164
of	<b>ਦ</b> ਦੁਸ਼	۲. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		Describe how in		City)
on	Attending ir death. ector: After by the fune	tlor	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 ☐ Yes 2	! □No			
Division of	of or Attendia after death. Director: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street City or Town, Sta		ural Route Number,
ā	s afte	Certification:	Sulding, etc. (Specify)				
	To the Hospitel or Attenwihin 24 hours after deatl To the Funerel Director:	<u>a</u>	29a. Certifier (Check only   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date   2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, or				
	the the the the the the the the the the	Medic	one) and manner stated.  29b. Signature and title of certifier 29c. License numb	er	29d. F	Date signed (Moni	h, Day, Year)
	To To cor		250. Signature and this of sorting				
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0-71		1-)	/
	6		Harry Li, m.D. 5755 Cedar Lane	, Colu	umbix,	MD 2	1044
	Sta Regist	ate rar	Harry Li, m.D. 5755 Cedar Lane  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 17 7004				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

5	6	0

			1 - For State Registrar		viarylana / B	Certificate	of De	ath		ig. No.	J 4 1	JD	13
П	Physici	an	1. Decedent's Name (First, Midd	lle, Last)					2. Date of Death Month	n Day	Year 3.	Time of I	Death
	/Medic		Α	nthony Joi	nes				May	09		:45	A M
1	Examir	ner	4a. Facility Name (If not institution	-		1		ation of Death		4c. County			
			East Bound Route 5				Bowie				ce Geor		
	Funeral Director		5. Social Security Number 215-64-4269  Usual Residence of Decedent	6. Sex 1 X M 2 ☐ F	Age (In yrs. last birt)			Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, April 6,	<sup>Year)</sup> 1954	9. Birthplace Country) German	(State or	Foreign
	and we		10a. State 10b. County	у	10c. City, Town	or Location					10d. Jr	nside Cit	v Limits
	Mary f ah	0	Maryland Montq	omerv	Silve	r Spring						□Yes	•
	the 288	Directo	10e. Street and Number	omer y	31170	10f. Zip (	Code	·	10	g. Citizen of W	hat Country?		
	3a or	<u></u>	9912 Edgehill	lano			0901			U.S.A	-		
	death ms 2	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. Was Decede		nic Origin? (Spe	cify Yes or No-		- American In	dian,	
9	or Ite		1 □ Never Married 2 🔀 Ma	rried Armed Force	s? ⊒No						, White, etc.		
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow after Examiner must be mutflied at	ğ	3 □ Widowed 4 □ Divorce	d Year or Date:	1976-1996	1ALIYes 2	⊔ No Sp	pecify: Puet	rto Rica	[] Specify:	White	е	
5-0	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or Items 23a or 28a-f ahow other than "natural", or Items 23a or 28a-f ahow event, the Medical Extrating must be multiled at	Completed		nt's Education est grade completed)	16a.	Decedent's Usual	Occupation	a most of worki	na 1	6b. Kind of Bu	siness/Industry	/	
Baltimore, Maryland 21215-0036	within iene.	du	Elementary/Secondary (0-12)	College (1-4c	N 5+)	(Give kind of work life. DO NOT use					29.		
2	Hygier Hygier ther ti		17 Fathada Nama (First Middle		2.	tate Tro		***		State o		land	
JUG	be fi	Be	17. Father's Name (First, Middle				18.		(First, Middle, N		9)		
₹	should be ind Mental a marked o umatic eve	2	Fred Jone					Josefir					
ā	12 sho h and 7 la mu trauma	0.1	19a. Informant's Name/Relation			Mailing Address (							
e,	s 1 and 2 should f Health and Mer item 27 la marke other traumatic		Eugenia Harpe 20a. Method of Disposition	r-Jones N		12 Edgeh <sup>a</sup> Disposition (Name			ver Spr	ing, Ma			01
و			1 X Burial 2 ☐ Cremation		Du fane	y changing g	ner place)	1					
	it. Partmer rtmer rtant njury		`4 □Donation 5 □ Other ( 21. Si navre of Fur ral rvice		Memor	ial Garde	ens	5-14-	2004	Timoniu	m Mar	rylai	nd
Ba	permit. Page Department of Important: If any injury or once.		and C	Hagan	_	1150 Ye	ork Ro	pad To	k Towson owson, Ma	nFunera aryland	1 Home: 2120	, Ind 1	c.
П			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause t only one cause on each	ed the death. Do no	ot enter the mode	of dying, su	ich as cardiac o	r respiratory arre	st,	Inter	roximate rval Betw	veen
	Physician .		Immediate Cause (Final disease or condition	MULT	IPUS T	MURIO	55				Ons	et and D	eath
	/Medical Examiner		resulting in death)		as a consequence o								
	Examiner	١.	Sequentially list conditions.	b									
	pe sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence o	f):							
	rtificate be executed ing physician and as the burial-transit	Examine	that initiated events resulting in death) Last	C. Due to (or :	as a consequence o	ξ\.							
60,	be ey ician buria			500 10 (0)	a consequence o	1).							
68760,	tificate b ng physic as the b	Medical		d				-					
			IF FEMALE:	23c. If yes, outcom	ne of pregnancy					22d Date	of delivery		
Box	death ce e attendi	hysiclan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death at time of death	3 ☐Ectopic pred				Mon	of delivery th Day	Ye	ear
o.	by the	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			J. J. J. J. J. J. J. J. J. J. J. J. J. J						
σ_	\$ B B	by Pt	Part II. Other significant condit	ions contributing to death	but not resulting in	the underlying car	use given in	Part I.	23e. Did toba	acco use contri	bute to the cau	use of de	ath?
rds	quires n sign ald be								1 🗆 Yes	2 12 No :	3 ☐ Probably	4 ∐Ur	nknown
of Vital Records,	w requires been si	ompleted							24a. Was an	24b. W	ere autopsy fi	ndings a	vailable
8	The law ate has b page 2 sl	E C							autopsy	ed? of	ior to completi ath?	ion of ca	use of
ta		Ö	25. Was case referred to medica	al			26	Place of Death	(Check only one		Yes 201	No	
>	Physician: this certific ral director,	0	examiner? 1X1 Yes 2 □ No	Hospital: 1 ☐ Inpa	itient 2∏ER/Out	patient 3 DOA	0		ne 5 Resider		(Conside) at		200
	g Ph er th	n:T	27. Manner of Death	28a. Date of Ir	jury 28b. Ti		c. Injury at Work?		8d. Describe how			. 500	Sile
0	를 <sup>무</sup> 돌 글	atlo	1 □Natural 5 □ Pendi 2 □Accident invest	igation 5-4-		Do A M	1 Yes	2 □ No	EDESTRI	AU STR	uar B	A Y	VAL
Division		ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 200. Place of	Injury - At home, fan etc. (Specify)		office	2	8f. Location (Stre City or Town,	et and Numbe	r or Rural Rou	te Numb	er, Mu
$\bar{\Box}$	spital or A ours after nerel Dire	Cer			600my			E	ART50 0	ATIAT BE	WIE PRIN	16560	Foreag
	e Hospital 24 hours e Funerel l	edical	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physician: To the bearing I Examiner: On the basis	st of my knowledge,	death occurred at	t the time, da	ate and place, a	ind due to the car	use(s) and man	ner as stated.		
	To the Hos within 24 ho To the Fun completely	Med	one) Z	and manner	stated								_
١	To To		29b. Signature and title of certific	D (16.10)	/	290.	License nun		29	d. Date signed		rear)	
	at.		montine !	10 re since			0.	C.M.E.		May 09	, 2004		
	15'1		30. Name and address of person  Margarita Kore		r death (Item 23a) (1	Type, Print) 111 <b>Penr</b>	Stre	et. Ral	timore.	Marvla	nd 2120	)1	
	Sta	te	31. Date filed (Month, Day, Year		strar Signature								
	Registi			Y 1 7 2004	Et al.	14 Ann	M 0 3	•					

		1	For State Registrar	State of Maryl		artment of lertificate of			giene Reg. No.2004	15620
	Physicia		1. Decedent's Name (First, Middle, I Joseph Julius Ki					2. Date of Dea	Day Year	3. Time of Death
	/Medic		1a. Facility Name (If not institution, g			4b. City, Town,	or Location of Deat	n	4c. County of Dear	
1	LAGIIIII	GI .	FRANKLIN SOU	LARE HOSPI-	FAL	Rose	dale		BALTIN	nore
	Funeral		5. Social Security Number 6		yrs. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day Sept. 3	h 9. Bird	hplace (State or Foreign puntry)
	Director	ļ.,	220 20 9010 Usual Residence of Decedent	75	115.			Sept. 3	0,1928   Mar	yland
	yland	l ⊢	10a. State 10b. County	100	City, Town or I	ocation				10d. Inside City Limits
	the Marylar 28a-f show	ctor	Maryland Baltim	ore	Essex					1 Tyes 2 No
-	with th	۵	10e. Street and Number 75 Weber Avenue			10f. Zip Code 212	21		10g. Citizen of What Co USA	ountry?
3	leath w	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13		Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No-		
36	filed within 72 hours after death with the Maryland Hygiene.  the than "natural; or Items 23a or 28a-f show the than "natural; or Items 23a or 28a-f show ant, Ite Madical Examiner must be notified at	by Fun	1 □ Never Married 2 【X Married 3 □ Widowed 4 □ Divorced	Armed Forces?		If Yes, specify Cul  1 ☐ Yes 2 ☑ No		o Rican, etc.)		<sub>e, etc.</sub> Thite
215-0036	2 hou natura	Completed	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occu	ipation	dking	16b. Kind of Business	Industry
12/	ithln 7 ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	1		eduring most of wo	nang	Chemical P	lant
2	lled w lygier her th	ပိ	8 17. Father's Name (First, Middle, La	est)	LOCOL	notive En	-	me (First, Middle,	Maiden Sumame)	lanc
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other fraumatic event. Its Mance.	To Be	George Krempel				Alice I		181 (6)	
<u></u>	should be and Mental s marked c umatic eve	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Stree	at and Number or Ri	ıral Route Numbe	er, City or Town, State, .	Zip Code)
Z.	and 2 ealth a n 27 Is		Ada Krempel (Wif				nue Balti			
ore C	of He of He If item	1	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	Removal from State	cemetery, cr	oosition (Name of ematory or other pl		Date	20c. Location - City or	
Baltimore,	tment of tant: If it		`4 □Donation 5 □ Other (Spe	city) E		Crematory		/2004	Baltimore,	Maryland
Ba	permii Depar Impo any ir		21. Sign ure of Funeral Service Li	sensee	1	22. Name and Addi Bruzdzins	ki Funera	1 Home I	P.A. ssex, Md. 2	1 2 2 1
	-		23a. Part1. Enter the disease, or co	omplications that caused the						Approximate Interval Between
	Physician		splock, or heart failure. List or Immediate Cause (Final disease or condition	Respir	ator	u Fai	lure			Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or as a cor	nsequence of):	7 1000	1,001			
	Lxammer	_	Sequentially list conditions,	b. Capto for as a por	· U.					
	nted I Insit	Examiner	Sequentially list conditions, it any, leading to annualist cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	be executed ician and burial-transit		resulting in death) Last	Due to (or as a cor	nsequence of):					
8760,	0 0	Physician/Medical		d						
9 ×	eath certifica attending pl for use as t	/Mec	IF FEMALE:	23c. If yes, outcome of pr	egnancy				23d. Date of de	liven
Вох	atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnan☐ Other (specify)	су		Month	Day Year
P.O.	that the ded by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
Vital Records, P	sign d be	by	Part II. Other significant condition	s contributing to death but no	t resulting in the	underlying cause g	jiven in Part I.	23e. Did to	obacco use contribute to res 2 No 3 P	o the cause of death?
000	aw request before a should	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
R	The tare has page	mo:						perfo	rmed? death?	2 □ No
/ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to edical examiner?	Manada				ath (Check only o	nne)	
of	Physic this c	2	1 ☐ Yes 2 ☐ No 27. Mann of Death		2 ER/Outpati	BIIL 3 DON			dence 6 Other (Spenow injury occurred	ecify)
ou	tending Pheath.	tion	1 Vatural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Yea ation	ar) Injury	W	ork? ⊒Yes 2 ⊒No		,,	
Division	l or Attending after death. Director: After in by the funer	ertification:	3 ☐ Suicide 6 ☐ Coulo no 4 ☐ Homicide dela min	28e. Place of Injury - building, etc. (S	At home, farm,	street, factory, office	9	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
Ö	ital or ral Di	0						L		
	To the Hospital or Attuvithin 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier 1 <b>W</b> Certifying (Check only one) 1 <b>M</b> edical E	Physician: To the best of my xaminer: On the basis of exa and manner stated.	y knowledge, de mination and/or	investigation, in my	opinion, death occ	e, and due to the urred at the time,	date and place, and du	to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	)		1	nse number		29d. Date signed (Mon.	n, Day, Year)
	11/		VVXZ	MO	(Itam 03a) (T		5 00000		May 14,	2004
_	Ve'		30. Name and ad ress of person w	V. SIDHAN	1E-000	D Frank	lin Squ	ARR Dri	Ve-Brettim	OFE MD. 2123
	St Regist	ate rur	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Souls				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryla	and / Dep		Health and M	nental Hyg	piene leg. No. 200	
I	Physici /Medi	al	Decedent's Name (First, Middle, Last     A. Facility Name (If not institution, give	Oralee Mar	y Kelle		or Location of Death	2. Date of Dea Month	Day Yea Y 13, 200	4 10:45A M
	Examir Funeral	ier	Saint Joseph h  5. Social Security Number 6. Se	1edical Cer	iter rs. last birthday					timore  inthplace (State or Foreign Country)
	Director		219-26-5012 Usual Residence of Decedent  10a. State  10b. County	□M 2⊠F 65	Yrs.  City, Town or L		Hours Miri.	Sept. 2	25,1938 M	aryland  10d. Inside City Limits
	ith the Mary or 28a-f sh	Director	Maryland Balt	imore		10f. Zip Code	Dunda		0g. Citizen of What	1 ☐ Yes 2 🖾 No
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel', or Items 23a or 28a-f show entry injury or other traumatic event, the Maried Examiliar must be neitlisd at once.	Completed by Funeral I	3203 Vulcan Road  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1 U.S. 13	Was Decedent of If Yes, specify Cut	21222 Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian,
Maryland 21215-0036	hin 72 hours 3. 3n "neturel", Madical Exc	pleted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi (Specify only highest grade  Elementary/Secondary (0-12)	Year or Dates:	16a. Deci (Giv life.	edent's Usual Occu		king	Specify: W	hite s/Industry
and 21;	d be filed will ntal Hygiene ed other the	Be	12 Years 17. Father's Name (First, Middle, Last)		I	Finance M		e (First, Middle, I	Law Fir	
	1 and 2 should be the leath and Mental I see 27 is marked oot ther treumatic eve	To	Francis Leo Kell  19a. Informant's Name/Relationship (7)  Mrs. Deborah H.	rpe, Print) Daughte				al Route Number	rine Spive City or Town, State agton, NC	
Baltimore,	t. Pages 1 a tment of He tent: If item		20a. Method of Disposition  1	Removal from State	cemetery, cre Sardens		cem. 5/1		20c. Location - City o	or Town, State
Ba	permi Depar Impor eny ir		21. Signature of Funeral Service Licens  23a art1. Enter the disease, or comp shock, or heart failing. List only o	•	I	7922 Wise	Funeral Ave. Du	ndalk, M		21222 Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	IRY FA: equence of): IBSTRUC	LURE				Interval Between Onset and Death
	ite be executed iysician and ne burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons	ANTI	FRYPSIN	DEFICIE	NCY		
.O. Box 68	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3	⊒Ectopic pregnand □ Other (specify)	ey		23d. Date of d Month	elivery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not r	esulting in the i	underlying cause gr	ven in Part I.	23e. Did tob		to the cause of death?  Probably 4 Unknown
al Records,	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed						24a. Was ar autops perform 1 Pes 2	y prior to	
<u> </u>	siclar certif recto	Be	25. Was case referred to medical examiner?	lospital:		Ot	26. Place of Deat			
o	Phys r this ral di	. To	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury	ER/Outpatie	nt 3□ DOA Do 28c. Inju	4 Nursing Ho	me 5 Reside	nce 6 Other (Sp	ecify)
5	ding h. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk? ]Yes 2 □No	200. 2000/100 /10	W Injury occurred	
Division of Vital	Hospitel or Attending Phy 24 hours after death. Funerel Director: After thi tely filled in by the funeral of	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st			28f. Location (Sti City or Town	reet and Number or F , State)	Rural Route Number,
	the the the	Medical		sicien: To the best of my k ner: On the basis of exami and manner stated.						
	To To Con		29b. Signature and title of certifier  30. Name and address of person who co	Luthe	W)		826	7	5- 3-04	in, Day, Year)
	4		RICHARD L. LINT	HICUM M.D.			RIVE MAR	OVE AND	21.204	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	land à		AT CHIMID	1.57/4	

I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Miller 05 12 Fletcher /Medical 4a. Fecility Name (If not institution, give street and number)

BALTIMORE VETERAN'S ADMINISTRATION CENTER BALTIMORE MD

5. Social Security Number

6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. (Month, Day, Year)

With the property of the propert 4c. County of Death **Examiner** 76 244-30-9030 Usual Residence of Decedent 08 21 10a. State 10c. City, Town or Location Directo Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3108 Mondawmin Ave 21216 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify. Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp 4yrs 12th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amanda Griffin Fletcher Miller Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3108 Mondawmin Ave, Baltimore Md Annie Mae Miller-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) King Memorial Park 5/18/04 Randallstown, Md 21. Signature of Funeral Service Licensee March F/H West Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failural List only one cause on each line. 4300 Wabash Ave, Baltimore Md

adult respiratory

failure

bilateral pneumonics

ar te appendiciti

Due to (or as a consequence of)

Dusito (or se a conecquence of):

Due to (or as a consequence of):

renal

23c. If yes, outcome of pregnancy

28a. Date of Injury (Month, Day Year)

1 Live birth 2 Fetal death

4☐Pregnant at time of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death

distress syndreme

Pnysician /Medical Examiner

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 X Natural

diabetes mellitus

chronic renal insufficiency

5 Pending

investigation

6 Could not be determined

multiple line related bacteremias

Hospital:

disease or condition resulting in death)

IF FEMALE:

**Funeral** 

Director

or ent: If item 27 is marked other then "naturel", or items 23a or 28a-1 show injury or other treumatic event, the Medical Examinar must be notified at

12 should ba fited within 7 and Mental Hyglene.

permit Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum

tha Maryland

Examine physician and s the burial-transit use as t the attending

After this certificate has

Physician/Medical Be Certification:

Box 68760 P.O. Division of Vital after death. death. Director: Hospital 24 hours a

within 24 hours a To the Funerel C completely filled in

the

Registrar

Medical

MONA DUNCAN, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

10 NORTH GREENE ST.

BALTIHORE

23d. Date of delivery 3 □Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ccronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1□ Yes 2XNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0060169 05-12-2004

mo

21201

Reg. No.

Year

2004

11:48

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2 No

NC

Black

21216

21215

Onset and Death

3 WEEKS

one month

one month

one month

, m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Injury

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** 3:36 pm Moye 10 2004 ma Laford David /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Mercy Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04 13 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months XIXM 2□ F Yrs. 53 SĆ Director 218-58-7520 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or flems 23a or 28a-f shor traumetic event, the Modical Examiner must be notified at 1X Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 U.S.A. 1702 North Dukeland Street Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify. Completed by 3 Widowed 4 Divorced Year or Detes: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 9th grade Unemployed na 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any Injury or other traumetic event 17. Fether's Name (First, Middle, Last) Unknown Be Betty Moye 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21207 5519 West Forest Park Ave, Balto, Md Veronica Whitehead-Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 5-15-04 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore Md 21215 1 23a. Part. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart fails. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Examiner ig physician and as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai Due to (or as a consequence of) usa 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 2 No 3 Probably 4 Unknown icie a Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? paga 2 1 Yes 20 No 1 ☐ Yes 2 ☐ No After this certificate funeral director, pag Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS ICC Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident within 24 hours efter deat To the Funeral Director: completaly filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the daath certificate be executed Ę

> State Registrar

edicai

29a. Certifier

(Check only one)

29b. Signature and tittle of certified

31. Dete filed (Month, Day, Year) MAY 1 7 200 k

3Q. Name and address of person who com: eted cause of death (Item 23a) (Type, Print) ber

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

29d. Date signed (Month, Day, Year)

S

State of Maryland / Department of Health and Mental Hygiene 2004 For Amend Item #16a per fh C831 5/17/04 to rtificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10.30 PM 05 2004 = SSIE 13th /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Howa 0 zenera 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day 5. Social Security Number 240-48-8688 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 X F NOF Carplino Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location tal Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event, the Neulcal Exercises must be notitied at 1 XYes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 041 death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Yes Give Specify Specify: ff Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☼ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Registered Nurse 0 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Importent: If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be mort 2 (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State t. Moriah Church Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Home 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleronic Cardio Vascular Disease **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖼 No P.0. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. page 2 should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 €No 2 ER/Outpatient 3 DOA ě Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1/⊠Natural 5 Pendina within 24 hours after death.
To the Funeral Director: After the funeral Director: After the funeral of the fune 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI )43725 (0 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back River Necle Rd Baltimon MAITMOOD 201-1001 2. Registrar's Signature State Registrar

			. For						Mental Hygi	iene COO	15000
_			1 - State Registrar		С	ertific	ate of l	Death	Re	g. No. 2001	1 15625
	Physici		1. Decedent's Name (First, Middle, Last)  Ruth Catheri		er				2. Date of Death	Day Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give			4b. C	ity, Town, or	Location of Deat	th	4c. County of De	ath
			GOOD SHMAR	TANHO	spita-L	13	Balti	more, 1		100	2
	Funeral Director		5. Social Security Number 6. Sex 212-01-6082	7. Age	94 Yrs. last birthda 94 Yrs	Mont	hder 1 Year hs Days	If Under 24 Hrs Hours Min.		9. B 1909	rthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
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	death with the Maryland ms 23a or 28a-f show rmust be notified at	i Dire	10e. Street and Number 2814 Pinewood Av	enue		10f.	Zip Code	21214	10	g. Citizen of What C United S	-
0	ems 2	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was De	specify Cuba	spanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
1772 LEF	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	d by Funeral	1 Never Married 2 Married 3 M Widowed 4 Divorced	1 ☐ Yes 2 💢 N If Yes, Give Year or Dates:	0		s 2 No	Specify:	to mican, etc.)		white
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land	be filed tal Hygi d other event, L	BeC	17. Father's Name (First, Middle, Last)						me (First, Middle, M	aiden Sumame)	
	should but marked umails	2	William C. Sch					Ruth	Virginia	Swann	
Mary	d 2 sh th and t7 is rr traurr		19a. Informant's Name/Relationship (Ty) Mrs. Claudia S. Tr	_				nd Number or Au Lakes [		City or Town, State,	
re,	s 1 and Heal		20a. Method of Disposition		20b. Place of Dis				the same of the sa	Oc. Location - City o	Yland 21013 r Town, State
Sp.	Page ment c ent: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Moreland				18/2004 I	Baltimore,	Maryland
Balt	permit. Page Department i Importent: If any injury of		21. Signature of Funeral Service License	Michael E.	Canapp		and Addres	•	53	05 Harfor	d Road
			23a. Part1. Enter the disease, or compli	cations that caused t	the death. Do not			. Ruck,		ltimore,	MD 21214 Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line	).		nodo o, dynig	, 30011 43 0410140	or respiratory arres	, , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):					<u> </u>	
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OM	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	consequence of):						
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9 X	death certificate b attending physions of for use as the b	/Мес	IF FEMALE:	3c. If yes, outcome o	f pregnancy	-					
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of C	Physic this co	ို	1 Yes 2 2H6	ospital:				4 ☐ Nursing H		ce 6 □Other (Spe	cify)
on o	ding Ph h. After th funeral	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury		28c. Injury Work	at ? es 2 □ No	28d. Describe how	injury occurred	
Division of Vital Records, P.O. Box 68	i tite	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)				28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Phys (Cneck only one)	ician: To the best of er: On the basis of e and manner state	examination and/or	ath occurr investigati	ed at the time ion, in my opi	e, date and place nion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				29c. License			d. Date signed (Mont	h, Day, Year)
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	5		30. Name and address of person who con	mpleted cause of dea	ath (Item 23a) (Typ Loch Ro	e, Print)	20 /	D D.1.		12 010	79
	Sta	6	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	ver1.	stud	150 CTI	nove, I	10212	7 7
	Registr		MAY 1 7 200	6/	A	Land	2				

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		For State	State of Maryland			nt of He te of D		id ivier			200	4 15	626
		Registrar  1. Decedent's Name (First, Middle, Last)				ic or D	Calli	2.1	Date of Dea	th		3. Time of	Death
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/Medic Examin	_	4a. Facility Name (If not institution, give s			4b. Cit	, Town, or L	ocation of D			4c. C	County of Dea		
		University of Mary		Center		Bal.	timo					plicable	
Funeral		5. Social Security Number 6. Sex 219-40-3742	7. Age (In yrs. I [M 2 F 60	ast birthday Yrs.	Month:		Hours M	Min.	Date of Birth Month, Day	Year)		hplace (State or ountry)	Foreign
Director		Usual Residence of Decedent						<u> </u>	rch 2	1 19	44 M	aryland	
yland		10a. State 10b. County		, Town or L								10d. Inside Cit	
e Ma	cto	Md. Baltimore	. Co. Re	eister								1 Tyes	2 <b>X</b> No
with th	Dire	10e. Street and Number 2351 Elderberry I	ano		10f. Z	ip Code 21136	,		'	10g. Citiz	en of What Co U.S.A	•	
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene.  d other than "naturel", or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Funeral Director		12. Was Decedent Ever in U.	S. 13	. Was Dec		panic Origin , Mexican, P	? (Specify	Yes or No-	14	4. Race - Am	erican Indian,	
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filed Hygi other	Be C	17. Father's Name (First, Middle, Last)				1	18. Mother's		rst, Middle,	Maiden S	,		
uld be Menta rrked ritic ev	To B	Samuel H.	Mc Cord Jr				Pau1	ine	В		Ma	ria	
Fe, INICAL YICATION AND STONDSONS 1 and 2 should be filled within 72 hours after death with the Marylan Health and Mental Hygiens. The literal 23 or 28s-f show other traumatic event, the Medical Examinat must be notified at		19a. Informant's Name/Relationship (Type Agnes J. Mc Cord	<sub>ре, Print)</sub> (Wife)								Town, State,	Zip Code) 21136	
E, R		20a. Method of Disposition	20b. P	lace of Disc	osition (N	ame of	1	Date			ation - City or		
Daltimore, permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cr	ematory of	other place,		/18/2	2004		ltimor		
Dalitimor Department of Department of Importent: If it Iny injury or o		21. Signature of Funeral Service Licensu		view							e P.A.	e, nu.	
Darmi Departi Impool any it		Jun S	Hainen		320	Mour	tain	Road	Paga	dona		21122	
		23a. Part . Enter the disease, or compliantick, or heart failure. List only or	cations that caused the death	n. Do not e	nter the m	ode of dying,	, such as car	rdiac or re	spiratory arr	rest,	,	Approximate Interval Bety	reen
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Of VItal Physician: 7 this certifical al director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpati	ent 3 🗆 1	Other	26. Place of				☐Other (Spe	acify)	
VISION Of VITA Attending Physician: r death. ector: Atter this certific by the funeral director,	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of	28c. Injury Work	at		Describe h				
Pndin path. or: Aft	atlo	1 Natural 5 Pending 2 Accident investigation	(ment)		М		es 2□No	)					
DIVISION  I or Attending after death. Director: Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, s	street, fact	ory, office		28f.	Location (S City or Tow		Number or R	ural Route Numi	oer,
Hospital of Phones at Funerel D		29a. Certifier 1 Certifying Physics	sician: Fo the best of my kno	wledge de	ath occurre	nd at the time	a date and r	nlace and	due to the o	rauso(s) s	and manner a	e etated	
24 hc 24 hc Fun	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or	investigati	on, in my opi	inion, death	occurred a	at the time, o	date and	place, and du	e to the cause(s)	
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20		30. Name and address of person who co				1 (	-	1 1	0	111		1 1	2.0
TV	100	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	- 2004	n Gre	ene S	120	Do	Him	rose M	eryland	21201
Sta Regist			7 200		Mr.	boule	8 -						

DHMH 17 Rev 1/2001

ORIGINAL

Unpend Tlem#23a,27,PFR ME,C831,5/27/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Roger LEE Mayles 04-03269 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 14, Physician 2004 0928 P. M Roger Lee Mayles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 233 Baltimore Avenue, Apt 3A Dundalk Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Director 218-72-9856 47 3/31/1957 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🕱 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 233 Baltimore Avenue Apt 3A 21222 S. A. withIn 72 hours after deeth Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Mechanic Automobile Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Heelth and Mental Important; If Item 27 is marked ery injury or other traumatic evonants. Floyd Mayles Gloria Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7415 Gunpowder Road Middle River, Maryland 21222 Mary Mayles (Ex Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5/17 Bayview Crematory 2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue lichar Essex, Maryland 21221 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one dause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Fatty Liver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 performed? certificete 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \tau \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 X Yes 2□ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident completely filled in by the **Director:** 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Contriving Physician. To the bast of my knowledge, Jeath Decard at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29d. Date signed (Month, Day, Year)
May 15, 2004 29b. Signature and title of certifier 29c. License number OCME MP Mulhouse Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MAMARITA KORELL 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 1 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 - For Stete Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ESTE CH KINA Month Vaar Physician ? 1055 ROZA 2004 /Medical 4c. County of Death

BALTIMORE 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL RANDALLITOWN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) UKRAINE 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 👿 F 96 220-35-3227 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 👿 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ UKRAINE 21209 2441 FOREST GREEN ROAD or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event. The Medical Examples Figures. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FACTORY TECHNICIAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **GREBEN** MESTECHKIN CHAYA MIKHAIL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2441 FOREST GREEN ROAD - BALTIMORE, MD 21209 GREGORY POLYAKOV / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State REISTERSTOWN, MD BALTIMORE HEBREW CEM: 5/14/2004 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. License 21. Signature of Funeral 89 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death = PSIS Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) DNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarrying Cause (Disease or injury Due to (or as a consequence of Examiner use as the burial-transit requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? for 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification; 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 \ Homicide 24 hours a e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar NITE

ALTO. MO 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

AV

31. Date filed (Month, Day, Year)

MAY 1 7 2004

		-	State of Maryland / Department of Health and M  1- State Registrar Certificate of Death		ene 2004	15629
			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Vera A. Neishel	MAY	14,2004	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Saint Joseph Medical Center  4b. City, Town, or Location of Death Towso	73		imore
	Funeral Director		5. Social Security Number 16. Sex 1 Months 1 Mon	8. Date of Birth (Month, Day, Y August 16	9. Birth Con 5,1920 Pe	nplace (State or Foreign untry) nnsylvania
	and	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla f sho	ō	Maryland Baltimore Timonium			1 ☐ Yes 2 🛣 No
	r 28a	Directo	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
	h with		9 Elphin Court Apt. 102 21093		U.S.A.	
	ams a	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or It	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Year or Dates:		Specify:	ام ا
Ö	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show iteal Examinat must be modified at		15. Decedent's Education 16a. Decedent's Usual Occupation	16	Bb. Kind of Business/	hite ndustry
<u>7.</u>	n na	plet	(Specify only highest grade completed)  (Give kind of work done during most of work)  Elementary/Secondary (0-12)  College (1-4or 5+)	ing		,
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Mar	ges 1 and 2 should tof Health and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rura</i> 126.00 Reveal Chapter Read	•		
بة ب	ss 1 and 2 of Health itam 27 I		June McIver Daughter 13608 Royal Crest Road  20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)		c. Location - City or	
Baltimore,	Pages nent of I ant: If its		1 X Burial 2 □ Cremation 3 □ Removal from State   Cemetery, crematory or other place)  1 Donation 5 □ Other (Specify)   Fern Knoll Burial Park 5-18	-2004 Da	allas Don	ncvlvania
altir	교원분들 .		21. Signature of Fun ral 3, rajo Licensee 22. Name and Address of Facility Ruc			
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest	t,	Approximate Interval Between
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
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Вох	eath certific attending pl	Physician/M	23b. Was decedent pregnant in the past 13 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delimental Month	very Day Year
O.	ne dea the at hed fo	/slcl	1   Yes 2   No 9   Unknown		WO.	51,
Δ.	that the de led by the a detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
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Records,	w requir s been si should	Completed		24a. Was an	24b. Were aut	topsy findings available
Re	The tav ate has page 2	omp		autopsy performe 1 Yes 2	d? death? TNo 1 ☐ Yes	ompletion of cause of
Vital		BeC	25. Was case referred to medical axaminer?	h (Check only one)		
of V	d is	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho		ce 6 □Other (Spec	ify)
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Division	or A after Dirac	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,		ar riosio rumber,
_	spital naral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,			
	To tha Hospital or Attanc within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date	and place, and due	to the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier  QUANTUM PM-Chla M.O  29c. License number	29d	I. Date signed (Month	, Day, Year)
)			9 7 min P 171-Enta M. O D 41410	W	194 14 1A	20ch.
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		,	
	(10		31. Date filed (Month, Day, Year) 32. Registrar's Signature	IN MARYL	OND 2120	14
	Sta Registr		MAY 1 7 2004			

			For State Registrer	State of N	Maryland / De	partmer ertificat					Reg. No. 2	004	15630
	Physici		Decedent's Name (First, Middle Casimeira	, Last)	Poj	gc				2. Date of De. Month May 13	Day	Year	3. Time of Death  2:15 P M
	/Medio Examir		4a. Facility Name (If not institution	, give street and number			Town, or	Location		Tady 13		ity of Death	2.13
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	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last birtho	Monthe	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da March 5,	h Y1 (127)	9. Birthp	place (State or Foreign ntry)
	Director		219-01-9208 Usual Residence of Decedent	71	92					Maidi J	1912	1410.	
	show		10a. State 10b. County		10c. City, Town o							1	0d. Inside City Limits
	8a-f s	octo	Md. Baltim	ore	Dund						10 011	/W	1 ☐ Yes 2 🕅 No
	with t	Funeral Director	10e. Street and Number 2926 Yorkway			TOT. ZI	Code 21	222			10g. Citizen o		tuy r
	ms 23	era	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. Was Dece			igin? (Spe	cify Yes or No Rican, etc.)		ace - Americ	
92	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Evantion must be notified at	y Fui	1 ☐ Never Married 2 ☐ Marr	If Yes, Give *	Νo	1 ☐ Yes		Specify:		nican, etc.)		lack, White, Pify: Whi	
215-0036	hours tural',	ed by	3 ₩ Widowed 4 □ Divorced	Year or Date	16a D	ecedent's Usu	al Occup	ation			16b, Kind of		
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Maryland	ould be fill Mental H sarkad oth	Be	17. Father's Name (First, Middle,						ər's Name qina	(First, Middle, Warmin	_	ame)	
الك	2 should and Men is marka aumatic	P P	Michael Warmin  19a. Informant's Name/Relations		19b. M	lailing Address	s (Street			l Route Numbe		m, State, Zip	Code)
	alth ar		Doug Popp	Son	292	26 York	way,	Dunc	dalk,	Md. 212	222		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If itam 27 is marked other than "natural", or Items 23s or 28s-f show Important: If itam 27 is marked other than "natural", or Items 23s or 28s-f show Important or other traumatic event, its Medical Evantor must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from Sta		crematory or o	other plac		_	ate	20c. Location	•	own, State
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Bal	permii Depar Impor any in		21. Signature of Fungral Service	Connel	204	Connel 7110 S	ly F	unera ers Po	il Ho Sint	me Of I Road, I	Dundalk Dundalk	,P.A.	21222
	Physician /Medical		23a. Part1. Enter the disea shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that causonly one cause on each	h line.	ANC		_	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
B	Examiner		Sequentially list conditions	BATR		3R 12							
	od sit	iner	Sequentially list conditions, many, reauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	αδ α συποέφμαπος σξ	550	10-	-11/1	B.	NON DIS	02		
	cate be executed obysician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or	as a consequence of)	3/ <del>5</del> /	461	112	140	D15	EASE		
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O. Box	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		n 2 ☐ Fetal death t at time of death	3 □Ectopic p 5 □ Other (s <sub>i</sub>					i i	Date of delive Month	ery Day Year
<u>α</u>	w requires that the been signed by th should be detache		Part II. Other significant condition	ons contributing to deat	h but not resulting in th	ne underlying (	cause giv	en in Part I			obacco use co Yes 2 ☐ No		he cause of death?
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Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Oth	W. 7		(Check only o			
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Division	o the Hospital or Attandi Ithin 24 hours after death. o the Funeral Diractor; A ompletely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of	Injury - At home, farm, , etc. <i>(Specify)</i>	, street, factor	y, office		2	28f. Location (S City or Tox		mber or Rura	al Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Diract completely filled in by	edical		ig Physicien: To the be Exeminer: On the basi and manner	s of examination and/o	or investigation	n, in my o	pinion, dea		ed at the time,	date and place	e, and due to	o the cause(s)
	To the within Comple	M	29b. Signature and title of certifie	Por K 1	Udka	29	c. Licens	e number	88	?	29d. Date sign	ned (Month,	Day, Year)
	5		30. Name and address of person	K July	of death (Item 23a) (Ty	(pe, Print)	770	ne	D	unda	DK 14	2) 2	2/222
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1	7 2004 P	istrar's Signature	6	pa	Kel	:: :				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 15631 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Pearce Phyllis Ann 10.2004 2:00p May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 73 209-24-6159 Plymouth, PA Director 9/17/1929 Usual Residence of Decedent with the Maryland 10c. City, Town or Location f show 10a. State 10b. County 10d. Inside City Limits r then "natural", or Items 23e or 28a-f sho The Medical Examinar must be notified at Rockville MD Montgomery 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 USA 5012 Jasmine Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2X Married 21215-0036 White 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Antique dealer Antiques ith and Mental Hygie 27 is marked other traumatic event, II Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillian Kodan Andrew Zarembo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Karen Helms/Daughter 5012 Jasmine Drive Rockville, Md 20853 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Maple Hill Cemetery 5/15/04 Hanover Twnsp, PA. 1 ₺ Burial 2 □ Cremation 3 □ Removal from State ö tment 4 Donation 5 Other (Specify) injury permit.
Departn
Imports
any inju uneral Service Lic 21. Signature PHILIPADOS RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) a Metastatic cervical cancer with brain metastases Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has funeral director, page 2 2 **X**No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  Nother (Specify)  $_{hospice}$ 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 🖾 Natural Injury 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison MD 6001 Muncaster MIll Rd Rockville, Md Registrar MAY 1 7 2004

			For	State of Maryland /	Department of Health and	Mental Hygie	ne 2001	15632
			State Registrar		Certificate of Death	Reg.	No. C O O S	3. Time of Death
П	Physici	_	1. Decedent's Name (First, Middle, Last)	Paremore		Month	Day Yeer	4:25 M
No.	/Medic Examin		4a. Fecility Name (If not institution, give s		4b. City, Town, or Location of Dea	ath	4c. County of Deeth	C.
			Malcolm Gro  5. Social Security Number 6. Sex	N RAICA C	Suitand	s. 8. Date of Birth	Prince	ace (State or Fereign
£	Funeral Director			M 2 F 50	Yrs. Months Days Hours Min		1953 FOGUNT	Fida
	pu .		Usual Residence of Decedent  10a. State 10b. County	10c. City. To	wn or Location		10	Od. Inside City Limits
	Maryla febo	ō	Macdard	Dis	trict Horah	t<		1 Kes 2 □ No
	or 28a	Director	10e. Street and Number	( )	10f. Zip Code	10g	. Citizen of What Count	try?
	ath wi	ral	3105 Lakel	nurst Ave	20741	Sanata Van as Na	14. Race - America	f Indian
10	fter de	Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	orto Rican, etc.)	Bleck, White, e	
21215-0036	be filed within 72 hours after death with the Maryland tal hygiene. Id other than "natural", or Iteme 23e or 28e-f ehow event, the Medical Examiner mail to mailfied at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give / Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: B	ack
15-(	in 72 h	Completed	15. Decedent's Educ (Specify only highest grade	completed)	<ul> <li>Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)</li> </ul>	orking 16	b. Kind of Business/Ind	lustry
212	d within giene. or then	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Vindow/Door In	staller	Medallion	n Security
		Be	17. Father's Name (First, Middle, Last)	Durana	18. Mother's N	ame (First, Middle, Ma	den Sumame)	/
Maryland	d 2 should be th and Mental 7 Is marked o traumatic eve	ဥ	19a. Informant's Name/Relationship (Ty)	DOB, Print) (SISTED) 15	9b. Mailing Address (Street and Number of	Rural Route Number, C	ity or Town, State, Zip	Code)
-	Tra Pa		Mrs Barbara	Bellamy	2215 Whittier	Ave. Be	elto. Ma	1.21217
Baltimore,	of t		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	/ come	of Disposition (Name of tery, crematory or other place)	Date 20	c. Location - City or Tov	wn, State
Him			<ul> <li>4 Donation 5 Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>		nWood (emetery)	3/2004	allahass	see, I-la
Ba	permit. Departr Imports any Inji		Desemble	L. Russ	Joseph L. Rus	S& Fune	ral Hom	21216
			23a. Part 1 Enter the disease, or complished, or heart failure. List only on	cations that caused the death. Do	o not enter the mode of dying, such as cardi	ac or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	andrae 1	my ha tal	ich		Oliset and Doam
Ш	Examiner		1	Due to (or as a consequence	e o0:			
6	P ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	u to or as a consequenc	Angel Dil	10		
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	10 Color - Junior			
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9	ertifica ling ph e as th	Med	IF FEMALE:	2- If you automa of promotors				
Вох	death certific e attending p ed for use as	clan	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver Month	ry Day Year
P.O.	0 0 0	Physician/Me	1 Yes 2 No 9 Unknown	9□ Unknown				
Ś	es pe	by	Part II. Other significant conditions con	ntributing to death but not resulting	g in the underlying cause given in Part I.	1	co usa contribute to the	
Vital Record	s been s should	Completed				24a. Was an	24b. Were autor	osy findings available
l Re		Comp				autopsy performe	d?/ death?	npletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	8	25. Was case referred to medical examiner?	lospital:	Other	eath (Check only one)		
of		n: To	27. Manner of Death	1 □ Inpatient 2 VEHV	b. Time of 28c. Injury at	Home 5 ☐ Residence 28d. Describe how	e 6 Other (Specify, injury occurred	")
ion	Attending death. ctor: Afte y the fun	atlo	1 Natural 5 Pending investigation	(Monin, Day Year)	Injury Work?  M 1 Yes 2 No			
Division	or Attendater death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
					ge, death occurred at the time, date and pla			
	To the Hospita within 24 hours To the Funeral completely filled	ledical	one)	and manner stated.	and/or investigation, in my opinion, death oc			
	To Too	Σ	29b. Signature and title of Catalier	Jan ) W	29c. License number	290	Date signed (Month, D	Jay, Year)
	1		30. Name and address of person who co	ompleted cause of death (Item 23a	a) (Type, Print)		TILLIA	
	M		PLOBERTINO N	2 Cur stof.	400 marlbors Rike,	Protest He	CM, They	70747
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 7 2004	32. Begistrar's Signature	& sports			

			For	State of Marylan				Mental Hyg	iene	15000
			State Registrar		Ce	rtificate of l	Death	2. Date of Deat	g. No. ZUU	4 15633
	Physici		1. Decedent's Name (First, Middle, La	RAILIB				Month	Day Sport	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	r Location of Death	11/19	4c. County of Dea	
		Ŭ.	EAST POIDT NU	PRSING+ REHI	1-B	EAST	POINT		BALTII	MORE
	Funeral		5. Social Security Number 6. S		last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Year 0 9. Bin	hplece (State or Foreign puntry)
	Director		Usual Residence of Decedent	0.5	113.			10118	11/0 0	7.5.4
	nyland show	_[	10a. State 10b. County	10c. City	y, Town or L	ocation				10d. Inside City Limits 1 Yes 2 □ No
	he Ma	Director	19D BALTIN	10LE E	HSTI	DINT		1 4	No Citizen of Miles Co	
	with the	10	10e. Street and Number	THE OD.	,	10f. Zip Code	11.		og. Citizen of What Co	s s
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame	nican Indian,
98	hours after death with the Maryland tural', or flems 23e or 28e-f ehow al Evantiset must be confibed at		1 Never Married 2 Married	Amed Forces?  1 Yes 2 No If Yes, Give		1 Yes 20 No	Specify:	nican, etc.)	Black, Whit	e, etc.
21215-0036		ed by	3 Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:		dent's Usual Occup	ation		16b. Kind of Business	Industry
215	within 72 ene. then "nai	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  Coltege (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work	ing		
		Com	NA			UNKNO				UOWH
Maryland	od ita	Be	17. Father's Name (First, Middle, Last,					e (First, Middle, N		
Ž	d 2 should I th and Meni 7 is marked traumatic	2	19a. Informant's Name/Relationship (	JOWN Type, Print)	19b. Maili	ng Address (Street a		NOW L	City or Town, State, 2	Zip Code)
Z	and 2 ; lealth ar m 27 is her trau		ARTHUR DA	AGERS OFFICE	10	U. CAL	VERT S	ST. #61	O BALTO.	MD 21202
ore,	- I 0 -		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐		lace of Dispo	osition (Name of matory or other place		Date 2	20c. Location - City or	Town, State
altimore,	Pa nent: ury		*4 □ Donation 5 □ Other (Special	y) He	dy 1	RINITY C	ery.	NOOK 1	BACTO. 1	UD.
Bal	permit. Departr Imports any inj		21. Signature of Fineral Service Licer	18 le le	2	2. Name and Address	ss of Facility	729 HU	MSON ST	224
	6 8		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death	h. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Atkon	1) 5ch	rote	Heart	Diseas	<b>6</b>	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):			<i></i>		
	Examine	35	Sequentially list conditions,	b. Due to (or as a consequ	uence of):	rosis				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	e be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
68760	<u> </u>	dicai		d						
9 x	The law requires that the death certificat tie has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	incy				23d. Date of del	iverv
. Box	death e atter d for u	iciar	in the past 12 months?	1 Live birth 2 Fetal		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	· 		Month	Day Year
P.0	that the de led by the detached	Phys	9 Unknown	9□ Unknown				00 01444		1
	signed	þ	Part II. Other significant conditions	Barillaling to death but not rest	uiting in the u	inderlying cause give	en in Part I.		acco use contribute to s 2 □ No 3 □ Pr	<u> </u>
cor	w require been sig should b	letec	The coals as	De Berry S				24a. Was ar	24b. Were au	itopsy findings available
Re	The lav	Completed	) 10401100 -9	1-1				autopsy perform 1 Yes 2	prior to death?	completion of cause of 2□ No
Vital Records,		BeC	25. Was case referred to medical examiner?					h (Check only one		
of \	g .s. d	2	1 ☐ Yes 2 ◯ No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatie		4 Nursing Ho	ome 5 Resider	nce 6 Other (Spe	cify)
	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	Work	Yes 2 □ No	200. Describe no	w injury occurred	
Division	Atter er dea ector by the	Certification;	3 Suicide 6 Could not be determined			reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
Ö	ital or irs afte ral Dir									
	he Hospital or Attending Pt n 24 hours after death. he Funeral Director: After th pletely filled in by the funeral	Medicai	29a. Certifier (Check only one)  1 Certifying Properties  1 Medical Example 1	nysician: To the best of my kno miner: On the basis of examina and manner stated.	tion and/or in	ivestigation, in my o	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (Monti	h, Day, Year)
			) mus	-16 my		201	11150		10/20	2004
			30. Name and address of person who	lornes, mo	23a) (Type,	5, ELL	ood A	UE, BAL	nd Date signed (Monti OS/10/3 To, MD d	21224
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	lovels!				,
	Regist	al .	WANY 1 77 2004	Andrew /		7				

Physician /Medical Examiner  Inez S. Redd  4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center  Funeral Director  S. Social Security Number 215-24-9655  Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Month Day Year MAY 13. 2004 4:00A  4c. County of Death Baltimore  4d. City, Town, or Location of Death Baltimore  9. Birthplace (State or For Country) Country) California  10d. Inside City L		1	For State Registrar	State of Maryla		artment <i>rtificate</i>			d Mental F		04 156
25. 24. 9555 ICM study Type 10c. Clay, Town or Location Tousand Tousan	/Medical Examiner	4	Inez S. F a. Facility Name (If not institution, give Saint Joseph	edd street and number) Medical Cen				Ton	Month heath	Day 1AY 13, 20 4c. County o	MØ4 4:00A fDeath altimore
Twenty depoted   Continued			215-24-9655	□M 2FXE					Min. (Month,	Day, Year)	9. Birthplace (State or For Country) California
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Bellementary (Secondary (D-12) College (1-for S-s) Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Is Mother's Name (First, Middle, Last)  Hugh  Red  Secretary  Secretar		1	Marital Status     Mever Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕅 No		Was Deceder If Yes, specify	nt of His Cuban	panic Origin , Mexican, P	? (Specify Yes or uerto Rican, etc.)	No- 14. Race Black,	American Indian, White, etc.
Bellementary (Secretary)  Credit Company  Secretary  Secretary  Is Mother's Name (First, Mickith, Makine, Sumarne)  Hugh Redd  Letter (Secretary)  Fig. (Secretary)  Redd (Secretary)  Secretary  Is Mother's Name (First, Mickith, Makine, Sumarne)  Mary E. Hockett  Hugh Redd  Letter (Secretary)  Secretary  Secretary  Is Mother's Name (First, Mickith, Makine, Sumarne)  Mary E. Hockett  Secretary	"natural", dical Ex-		15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual (	Occupat	ion	working		
Hugh Redd  Hugh Feather Felezitonship (Type, Prof)  196. Mailing Address (Street and Number, Color or Town, State, 25 Code)  197. Mailing Address (Street and Number, Color or Town, State, 25 Code)  198. Mailing Address (Street and Number, Color or Town, State, 25 Code)  198. Mailing Address (Street and Number, Color or Town, State, 25 Code)  198. Mailing Address (Street and Number, Color or Town, State, 25 Code)  198. Mailing Address (Street and Number, Color or Town, State, 25 Code)  198. Mailing Address (Street and Number, Color or Town, State, 25 Code)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  198. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailing Address of End of Deposition (Name of Deposition)  199. Mailin	her than nt. It a Me						ry		<u> </u>		
1 C Bursial 2 @ Cremation 3   Removal from State   Hill Don Store. Corp.   O5/14/2004   Towson, MD    24 C Donation 5 C Other (Speechy)   21. Significant Conditions and Store   Store   Corp.   O5/14/2004   Towson, MD    25 Amai and Address of Facility   Ruck Towson Funeral Home, International Cause   Facility   Company   Com	narked ott atic even		Hugh	11000			İ	Mar	y E.	Hocke	tt
Carried and Committee   Carr	7 la m traum	l		ype, Print)							
23. Part 1 first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical cause (Final medical cause on each fine).  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Part I first the disease, or complications are diseased.  Part I first the disease, or complications are diseased.  Part I first the disease, or complications are diseased.  Part I first the disease, or complications are diseased.  Part I first the disease.  Pa	at: If item 2 ry or other	2	0a. Method of Disposition 1 ☐ Burial 2 🎽 Cremation 3 ☐	Removal from State	Place of Dispo	sition (Name	of er place)	, 1	Date	20c. Location - C	ity or Town, State
23a. Part. 4 files the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final International Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of the Properties of the Control of t	Importar any inju	2		80						son Funera	al Home, In
25. Was case referred to medical examiner?  1	nysician and he burial-transit cal Examiner	t	Jause (Disease or Injury hat initiated events esulting in death) Last	Due to (or as a consect.  Due to (or as a consect.	quence of):						
25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death  27. Was an autopsy findings available of cause of death of the cause	by the atten tached for u hysician		in the past 12 months?  1 \(\sum \text{Yes}  2 \)  1 \(\sum \text{Yes}  2 \)	1 Live birth 2 ☐ Fet 4 Pregnant at time of	al death 3						
25. Was case referred to medical examiner?  1   Yes	gne be d	1	art II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying caus	se given	in Part I.			8
27. Manner of Death   Natural   2   2   2   2   2   2   2   2   2	S C D								aut per	opsy prio formed? dea	r to completion of cause th?
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	irecto Be	2	examiner?	Hospital:	750/0						
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D 37254 5/13/04	Director in by the ertific		4 Homicide determined	building, etc. (Speci	ify)				City or To	own, State)	
D 37254 5/13/04	E 0	2	one)	ner: On the basis of examin	owledge, death ation and/or inv	occurred at t estigation, in	he time, my opin	date and pla ion, death o	ace, and due to the courred at the time	e cause(s) and manne , date and place, and	er as stated. I due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	the Funeral opletely filled redical C	$\vdash$	Oh Cionatura and title of cortifier			29c. Li	icense n	umber			
	To the Funeral completely filled	2	90. Signature and title to the title	me Jun	<u>C</u>	D .	372	54		5/13/0	4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM #18 PER BI G831 5/17/04 Jh 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** MXY Ϊ́З, 2004 ROSENBERG LENA 8:30 A /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Dey, Year) NOV. 2, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 ☐ M 2 ☑ F 88 119-01-9971 Yrs Director PA Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Dependrant of Health and Mentel Hyglene. Important: if tem 27 is marked other than "natural", or tems 23s or 28s-7 show enly Inlury or other traumatic event, the Medical Examiner may be notified at 10e, Stete 10b. County 10c. City, Town or Location d other than "natural", or frems 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3804 MCDONOGH ROAD 21133 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **COOPERMAN** ဥ WILLIAM MOLLY -GREENFARB GREENFARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK MORRIS / FRIEND 22-C DEER RUN COURT, BOX 7 - ARBUTUS, MD 21227 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriet 2 Cremetion 3 Removal from State 4 Dona 5 Other (Specify) HEBREW YOUNG MEN CEMETERY 5/14/04 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signa uneral Service Licer 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, y one cause on each line. Part1. Enter the diseese, or com shock, or heart failure. List only Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Lunuwn Examiner Due to (or as a consequen-Physician/Medical Examiner To the Hospital or Attending Physician: The law raquiras thet the death certificeta be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician endorpolately filled in by the funered interestor, page 2 should be dateched for use as the burnai-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Be Completed by After this certificate has been si funerel director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tyes 2 ₹No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 2 ☐ Accident 1 Tes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29b. Signature end title of certify 29d. Date signed (Month, Day, Year) MID 30. Neme end address of person who complete cause of,death (Item 23e) (Type, Print) 21208 eman 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAY 1

Sporks

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 2:18 A<sup>M</sup> MAY 2004 ALEJANDRO (NMN) GARCIA RIVERA 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 € M 2 □ F Mexicali B.C. Director 16 623-42-9193 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel', or tiems 23a or 28e-f show any injury or other treumatic event, the Madical Examiner and be putified at once. 1 ☐ Yes 2 No Mexicali B.C. Funeral Director 10f. Zip Code UNK 10e. Street and Number 10g. Citizen of What Country? Laueles 486 Frac LOs Pinos Mexico 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 yes 2□No Specify:Mexican Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MArcia Rivera Alejandro Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alejandro Garcia/Father Laueles 486 Frac. LOs Pinos Mexical B.C. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Jardin de la Esperanza 5-18-04 B. C. Mexico 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Reiniratury **Physician** -allutt /Medical Due to (or as a consequende of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner monoblastic leukemia. or Attending Physicien: The law requires that the death certificate be executed burial-transit Kelanic Acute and Due to (or a a consequence of) Division of Vital Records, P.O. Box 68760 Medical Certification; To Be Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? transplant Hunloidentical 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 No this After thi funeral o 28a. D. te of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending Nothin 24 hours after death.
To the Funerel Director: Aft 1 Tes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0101234568 VA ayord MI who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ALDEMAR MONTERO 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, MAY 32. Registrar's Signature 1 5 2004 State Registrar

			1 - For State Registrar	State of M	aryland /	_	artment rtificate			and M		Reg. No.	2004	15637
	Physici		Decedent's Name (First, Middle, I  John	Last)		S	achs				2. Date of De Month MAY 13	Day	004	3. Time of Death  10:59 PM
	/Medic Examir		4a. Fecility Name (If not institution, g	give street and number)			4b. City, T	own, or	Location o	f Death		4c.	County of Death	1 2000
			BAYVIEW MEDICAL		"				ORE C				N/A	
	Funeral Director		216-86-8314	. Sex 7. Ag	ge (In yrs. last i	Yrs.	If Under 1 Months	Days	If Under: Hours	Min.	8. Date of Birl (Month, Da May 14	196	8 9. Birthp Court MD.	lace (State or Foreign try)
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	ocation						1	Od. Inside City Limits
	the Marylan 28a-f show	tor	MD. Baltin	ore		Dund	alk							1 ☐ Yes 2 📉 No
	oth with the 23a or 28 ust be mul	ii Direc	10e. Street and Number 1525 Rita Road				10f. Zip (	Code 2122	22				en of What Cour SA	itry?
36	iges 1 and 2 should be filed within 72 hours after deeth with the Maryland to f Health and Mental Hygiene. If item 27 le marked othar than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Exatura institue to diffice at	by Funeral Director	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	)		Was Decede		spanic Orion, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	2 hou	ted	15. Decedent's	Education	16	Sa. Dece	dent's Usual	Occupa	tion	t a f trea whei		16b. Kin	nd of Business/Inc	dustry
218	ithin 7 ne. nan "r	Completed	(Specify only highest s Elementary/Secondary (0-12)	College (1-4or			kind of work DO NOT use			or worki	ng			
	iled w dygier thar th		11 years  17. Father's Name (First, Middle, La	et)		Grou	ınds K			r'e Name	(First, Middle,		nstructi	on
Maryland	2 should be filed withir and Mental Hygiene. Ie marked othar than aumatic event, Ito M	To Be	Benson Sacks			Rachuba		Jumamej						
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number 9219 Seven Courts D  20a. Method of Disposition  20b. Place of Disposition (Name of													
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3	☐Removal from State		ate	20c. Loc	cation - City or To	wn, State					
ţ	Pant and Lry		` 4 ☐ Donation 5 ☐ Other (Spe	cify)	Bayvi	. T	cremate			_	-		timore C	
Bal	permit. Departr Imports any inji		21. Signature of Funeral Service Lie	C. Com					dalk,P.A dalk,Md.					
			23a. Part . Enter the disease, or co shock, or heart failure. Ust on	omplications that cause ly one cause on each li	d the death.	o not ent	er the mode	of dying	, such as	cardiac c	r respiratory ar	rrest,		Approximate Interval Between Onset and Death
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	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease of Pillury	b. — Due to (or as	a consequenc	e of):								
	sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	a of\-								
8760,	ate be ex nysician he buria			500 to (6) da	u consequenc	o 01).								
9	tificate ig phys as the	ledic		0.										
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		Ectopic pred Other (spec					2:	3d. Date of delive Month	ry Day Year
Δ.	res that t igned by be deta	by Ph	Part II. Other significant conditions	s contributing to death b	out not resulting	g in the u	nderlying cau	use give	n in Part I.		23e. Did to	obacco us	se contribute to th	e cause of death?
rds	w requires been sign should be						_				1 🗆 Y	∕es 2.2	No 3 ☐ Prob	ably 4 □Unknown
Records,	9 <u>~ 9</u>	Completed									24a. Was autop perfor	sy	prior to con death?	osy findings available inpletion of cause of
Vital		Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		10.100	
of V	hye this al di	P	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatio			nt 3□ DOA	_	4 LI INUI				Other (Specify	)
ou c	fing After fune	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da		Injury		c. Injury Work'	at ? es 2.25%\		28d. Describe h		occurred KAN	POINT-
Division	l or Attanding after death. Diractor: After in by the fune	Certification:	3 Suicide 6 Could not	be 28e. Place of In	(FOUND) For			_			28f. Location (S	Street and	Number or Rura	
Ö	i e c	Certi	4  Homicide	RESIDE	c. (Specify) VCE					1	SZS RIT		, AUNDAL	K, MO
	To the Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by	edicai (	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☒ Medicel Ex	Physician: To the best aminer: On the basis of and manner st	f examination a	lge, deatl and/or in	n occurred at vestigation, i	t the time in my opi	e, date and inion, deat	d place, a	and due to the dead at the time, o	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	40				License					signed (Month, L	
	0		> linete					0 C	M E			MAY	14, 200	4
	18		30. Name and address of person when AMA-R	WB10 M		a) (Type,		1 P€	enn S	tree	t, Balt	imor	e, Maryl	and 21201
	Sta Regist		31. Date filod (Month, Day, Year)  MAY 1 7 20		ar's Signature	4	Spa	the same	, :					

			1 - For State Registra AMEND IIEM #18 1. Decedent's Name (First, Middle, L						2. Date of De		3. Time of Death
	Physicia /Medic		William	Anthony		Shi	fflett		Month	13, 2004	4:54 P M
	Examin		4a. Facility Name (If not institution, ga	ve street and number)			4b. City, Town, c	r Location of Death		4c. County of Dea	
			Gilchrist Center				Towsor			Baltimo	
	Funeral		5. Social Security Number 6. 215–60–2152	Sex 7.Age XXM 2□F		8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h 9. Bi	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	741		1.5.			April 4	, 1956 M	D <b>.</b>
	laryland show		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Md. Baltimo	re	Du	ndalk					1 ☐ Yes 2 ☐XNo
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
	s 23a		809 Jeannette Ave		one in II O	140.1	21222			USA - 14. Race - Am	ariana ladina
	ter dea fams	Funeral	11. Marital Status 1 ☐ Never Married 2 ▼ Married	12. Was Decedent E Armed Forces? 1 Yes 2 X		. 13. V	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whi	
30%	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2☐XNo	Specify:		Specify: Wh	ite
50.5	72 ho natur fical	Completed	15. Decedent's I (Specify only highest g	ducation		16a. Deced	ent's Usual Occup	pation during most of work	ina	16b. Kind of Business	s/Industry
212	ithin ne. han "	mpie	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of work d)	9		
54	fled w fygier har ti		12 years 17. Father's Name (First, Middle, Las	t)	l.	Route	e Driver	18 Mother's Name	a /First Middle	Delivery Maiden Sumame)	
<i>ು3ೌಲ ಳಽ೪</i> // Maryland 21	s 1 and 2 should ba filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked othar than "naturel", or ftams 23a or 28a-f show other traumatic svent, I'm Medical Examerations I a	Be c	William M. Shiff	,						ando DINARDO	
Z Z	should Me mark matin	To	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street			er, City or Town, State,	Zip Code)
Ma	and 2 sealth ar n 27 is ner trau		Kathleen Shifflet	t wife	e .	809	Jeannette	e Avenue,	Dundalk	,Md. 21222	
Hursony, May I. Baltimore, Ma	is 1 and 2 of Health item 27 i		20a. Method of Disposition				sition (Name of natory or other place		Date	20c. Location - City or	
7. / mo	Page nent c ant: If ury or		1 Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec	□Removal from State ify)		Cemetery		17,2004	Dundalk, M	D.	
SDAY, MA Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Lice	ensee		00 2	Name and Addre	ss of Facility Ho	ome Of L	Dundalk,P.A	
SZO I	80 5 5 8		Chithory	C. Cor	rne	egy 7	10 Soll∈	ers Point	Road, I	Dundlak,MD.	21222
左			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	nplications that caused y one cause on each lin	the death. e.	Do obt ente	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Esopt	age	al a	cances				4005
	/Medical Examiner		Toolstang in douting	Due to (or as a	a conseque	ence of):					
		-E	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	a conseque	ence of):					
X	uted d ansit	Examiner	Cause (Disease or injury that initiated events								
Ó	te be exacuted ysician and ne burial-transit		resulting in death) Last	Due to (or as a	conseque	ence of):					
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ر 68 68	ing ph	Med	IF FEMALE:								
16 Bo	death certificat e attending phy id for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth	2 Fetal o	death 3	Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
<i>⊙</i> ⊙	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5∟	Other (specify)				,
न वं	de de de	/ Ph	Part II. Other significant conditions	contributing to death bu	it not result	ting in the ur	derlying cause giv	ren in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
3-ds	uires I sign Id be	d by							1)(2)	′es 2 □ No 3 □ P	robably 4 Unknown
U5-13 ecord	> 42 (6	Completed							24a. Was	an 24b. Were a	utopsy findings available
7 Be	0 5 0	шо							autop perfo	rmed? prior to death? 2 No 1 Yes	completion of cause of
ital	iicien: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Deat			2010		
William 05-13-09 of Vital Records, P.	di is	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1  Inpatie	nt 2 🗆 E	R/Outpatien	3□ DOA Oth	er: 4 Nursing Ho	me 5 Resid	lence 6 Other (Spe	ocity) Hospice
ર્ું ૄ			27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	low injury occurred	
_ 0	r Attending er death. rector: After by the fune	ertification:	2 Accident investigate 3 Suicide 6 Could not	he				Yes 2 □ No			
3 :0	of or Attence after death Director:	ırtifi	4 Homicide determine		ry - At hon : (Specify)	ne, farm, stre	et, factory, office		City or Tou	Street and Number or R m, State)	ural Houte Number,
FLE!	<u> </u>	w		hysician: To the best of	f my know	ledge death	occurred at the tir	ne, date and place	and due to the	cause(s) and manner a	s stated.
Division	pritel ours all ours all leral D	C	29a. Certifier 11/1/Cartifying F		examination	on and/or inv	estigation in my d	pinion, death occurr	red at the time,	date and place, and du	o otatou.
MIFFLE! Division	Hospitel 24 hours Funeral stely filled	dicai	29a. Certifier 1 D Certifying F	miner: On the basis of and manner sta	ted.		oonganon, army o			sais and place, and de	e to the cause(s)
Divisio	Hospitel 24 hours Funeral stely filled		(Checketting 2 Medical Exa	miner: On the basis of	ted.		29c. Licens			29d. Date signed (Mon	
SKIF FLET Division	To the Hospitel of within 24 hours at To the Funeral D completely filled it	edicai	(Check-only 2 Medical Extrapolation)	miner: On the basis of	ted.		29c. Licens			29d. Date signed (Mon	
SALF FLET Division	Hospitel 24 hours Funeral stely filled	edicai	(Check-only 2 Medical Extrapolation)	iminer: On the basis of and manner sta	ted.		29c. Licens	28703		29d. Date signed (Moni	th, Day, Year)

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			1 - For State Registrar	State of Marylar		ent of Health and		^ ^ -	1500
		_		-11	Certifica	ate of Death	Reg. 2. Date of Death	. No. 2001	÷ 15535
п	Physici	an	1. Decedent's Name (First, Middle, La	CHAO	- Crist	•	Month	Day Year	3. Time of Death
W.	/Medic	al	4a. Fecility Name (If not institution, giv	a street and number)	0 5 0 5	ity, Town, or Location of Dea	TINY	4c. County of Deet	
	Examin	er	Seril LA	REL Provi	- RD	RolesiF		DC	00.
	Funeral	•	5. Sociel Security Number 6. S	Sex 7. Age (In yrs.		der 1 Year If Under 24 Hr	s. 8. Date of Birth	9. Birt	hplace (State or Foreign
а	Director		236-64-5048	OM 200 63	Yrs. Month	ns Days Hours Mir	8. B. Date of Birth (Month, Day, You	17.1941	untry) 12. VA
	р.		Usual Residence of Decedent  10a, State 10b, County	100.0	ty. Town or Location				10d Amida Citatiania
	anyla shov	ř	10a. State 10b. County	1 0- 100.0	Z Cation				10d. tnside City Limits 1 XYes 2 □ No
	he M	ecto	10e. Street and Number	3. Co. [	10001E	Zip Code	100	. Citizen of What Co	
	with	Ö	Ro 314 Lande	1 Barrie	07	20415	109	/) <	M -
	death with the Maryland ms 23s or 28s-f show Emust tet notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was De	cedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ame	
S	or Itan	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		~/	rto Rican, etc.)	Black, White	e, etc.
<u>8</u>	hours after turel', or Ita	1 by	3 Widowed 4 Divorced	tf Yes, Give Year or Dates:	1 L Yes	s 2DNo Specify:		Specify:	UHITE.
21215-0036	72 ne	Completed	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a. Decedent's U (Give kind of	work done during most of w	orking 16	b. Kind of Business/	Industry
121	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Bo DO NO	Tuse retired)		BAR	
20	filed v Hygie other		17. Father's Name (First, Middle, Last	)	DIFK	18. Mother's No	ame (First, Middle, Mai	den Sumame)	
an	d be antal	To Be	UNKNOWN	CINTS		/ > W	KNOW	()	
Maryland	shou nd M mar	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Addr	ess (Street and Number or I			Tip Code) 20115
ž	s 1 and 2 should if Health and Mer item 27 is marks other traumatic		MICHAEL SH	EGOGUE	8034	LAUREL B	WIE RI	Bowin	- M/
ore,	of Hei of Hei fitem rothe		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposition (I		Date 10 200	. Location - City or	Town, State
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			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the dea one cause on each line.	the Do not enter the m	node of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
į.	Physician		tmmediate Cause (Final disease or condition resulting in death)	a. Ling	cancer				3 no.
В	/Medical Examiner		Tosaking in doubly	Due to (or as a conse	quence of):				
П		er	Sequentially list conditions,	b. Due to or as a cons	uence of				
	uted	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events						
Ć	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):				
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89	death certificate e attending physi d for use as the	Physician/Medi	IF FEMALE:						
Box	eath certif attending for use a	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	el death 3 Ectopic	pregnancy		23d. Date of deli	very Day Year
0.	the all	sici	1 Yes 2 No	4☐Pregnant at time of o	death 5 Other	(specify)		World	July 100:
Φ.	requires that the de een signed by the a nould be detached	Ph	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlyin	g cause given in Part I	23e. Did tobac	co use contribute to	the cause of death?
Records,	Se P. 60	d by		<b>.</b>	<b>,</b>	<b>3 3</b>			obably 4 Unknown
Sor	w require been si should t	lete					24a. Was an	24h Were au	topsy findings available
Re	e la has	Completed					autopsy performed	prior to death?	completion of cause of
Vital		a	25. Was case referred to medical			26 Place of De	1 ☐ Yes 2 ☐	No 1 Yes	2 No
>		To B	examiner? 1 ☐ Yes 🚵 No	Hospital:	ER/Outpatient 3	Other	Home Residence	e 6 ∏Other (Spec	cify)
J of	g Physier this		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		,
Division	Attending I r death. ector: After by the funer	Certification:	2 Accident 5 Pending investigation	n	М	1 Yes 2 No			
ivis	or Attendation of the properties of the properti	tific	3 Suicide 6 Could not be determined		ome, farm, street, fact	tory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	itel o	Cer		li .					
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exe	nysician: To the best of my kn miner: On the basis of examin	owledge, death occurr ation and/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	thin 2 thin 2 the mplel	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	29d	Date signed (Month	1. Day Year)
	F 3 F 8		12/	Mr.	w	73587		/ /	
	8		30. Name and address of person who			V V (		5/10/0	
	C)		·			Lane #110	30W(E	MD De	715
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	atife for	K.			
	Registr	ar	MAY 1 7 2004	1	- jayou				

			1 - For State Registrar	State of Ma		Departmer Certificat	t of Hea	aith and N	lental Hy	_		15640
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last Charles Christian	n Simon		4.00			2. Date of De Month	14 2		3. Time of Death
	Examir Funeral Director	ner	5. Social Security Number 217 26 7054 Us. Se	ARE HOS	(In yrs. last bii	R	OSE a	Under 24 Hrs.	8. Date of Bii (Month, De NOV 22	4c. County B A th ay, Year) 1930	ITi	MORE  place (State or Foreign  pland
·	ith the Maryland or 28a-1 show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimon		10c. City, Tow Midd	n or Location lle Rive					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
MON	uth with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 7318 Greenbank Ro	ī.		10f. Zip	Code 21220			10g. Citizen of USA	What Cour	try?
+	BAITIMOFE, IMARYIANG Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show myn injury or other traumatic event, it is Medical Examinar roust be mutified at once.	b	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 [XYes 2 □ No If Yes, Give 1 Year or Dates:		13. Was Dece If Yes, spe		anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specif	ce - Americ ck, White, y: Wh	
5	Maryland Z1Z13-UU35 tid 2 should be filed within 72 hours aft th and Mantal Hyglene. Z7 is marked other than "natural", or traumatic event, the Moutical Exprin	Be Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+		Decedent's Usu (Give kind of wo life. DO NOT u Elect	al Occupation rk done during se retired)	ng most of work	ing	16b. Kind of B		lectricity
NARle	aryland Z should be filed nd Mental Hygis marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last)  John L. Simon				18		e (First, Middle Zwick	, Maiden Suman		
	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (T Naomi Simon (Wife)		73	. Mailing Address 318 Greer	ıbank 1	Rd. Bal	timore,	er, City or Town, Md. 21.	, State, Zip 220	Code)
	Salfimore, bernit. Pages 1 a Department of Hee mportant: If item any injury or othe		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ I  1 ☐ Donation 5 ☐ Other (Specify,	)	1	f Disposition (Nat ry, crematory or c ns Of Fa		5/18/	2004	20c. Location Baltimo		wn, State Maryland
Č	Departition of the control of the co		21. Signature of Funeral Service Licens	Tallar	51.		inski )ld Ea:	Funera stern A		P.A. ssex, M	d. 21	221
•	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or copies shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	Due to or as a	consequence	eluke		uch as cardiac	or respiratory a	rrest,	- 1	Approximate Interval Between Onset and Death
	Attending Physician: The law requires that the death certificate be executed or death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	edicai Examine	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence	of):						
	F.C. BOX 08 nat the death certifical by the attending pt letached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death	3 □Ectopic pr 5 □ Other (sp					te of delive onth	<b>ry</b> Day Year
	v requires that	þ	Part II. Dther significant conditions co	ntributing to death but	not resulting in	n the underlying o	ause given ir	Part I.	23e. Did t	/		e cause of death?
2	al hecor : The law requested has been ; page 2 shoul	Completed							24a. Was autor perfo 1 \( \text{Yes} \)	osy	Were autop prior to con death? 1  Yes	osy findings available inpletion of cause of
	Or VICAL Physiclan: The Physiclan: The raths certificate ral director, page	To Be	25. Was case referred to medical examiner?  Yes 2 \( \sum \) No  27. Manner of Death		2 ER/Ou		A Other:		me 5∐ÎResid	one dence 6 □Oth now injury occur		)
X	VISION C r Attending P er death. rector: After by the funera	Certification:	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	y - At home, fa	М		2 □ No		Street and Numb		Route Number,
Č	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	dical Cer	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	my knowledge	e, death occurred	at the time, o	date and place,	and due to the	cause(s) and ma	inner as sta	ited.
	To the P within 24 To the F complete	Med	one)  29b. Signature and title of certifier	and manner state	od.	290	. License nu	mber		29d. Date signed	d (Month, L	Day, Year)
	101/		30. Name and address of person who co	ompleted cause of va	th (Item 23a)		)335 . D.	#314	Roll	May	17,	232
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 1 7 2004	32. Registrar	s Signature	Spork	10	11 " 1	11/1/6	mpe		77

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Theresa K. Schuman **Physician** 7:00 P M May 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Towson Gilchrist Nursing Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖸 F Yrs. Director July 29,1932 Maryland 213-28-3853 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itam 27 is markad other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Modical Examinar must be mutified at 1 ☐ Yes 2 🛛 No Dunda1k Directo Baltimore Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 705 Wise Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Schuman, Theresa 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 7 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be and Mental Cecelia A. Wolferman Andrew J. Lauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, Maryland 21220 Marie Schuman Daughter 37 Transverse Ave. ges 1 and 2 it of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot ¥28urial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 5/14/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Jury 1 Serv 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage obstructive lung disease **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician certificate be Physician/Medical use IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? llitus 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attanding Pl
 A hours after death.
 Funaral Director; After the 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)25205 MAY 11, 200x un) 30. Name and address of person who completed and of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21204 6701 BMC 32. Registrar's Signature 31. Date filed (Month 2004 1101115 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 15642 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** ELIZABETH ANN SULLIVAN MAY 2004 7:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 532 PONTIAC AVE. BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F 62 Director 216-36-1733 July 31 1941 Marvland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examinar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tv☐Yes 2☐No Md. Baltimore n/a Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 Pontiac Ave. 21225 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Csinko Margaret ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon D. Trego 3380 Crane Road, Port Republic, Md. 20676 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 05/14/2004 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee moog22 237 E. Patapsco Ave. Baltimore, Md. 21225 23a. Part1 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been sig Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rector, page 2 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗆 Inpatient ဥ this ( 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending within 24 hours are. \_\_\_ You the Funeral Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Baltimore, 4D21201 es/18 Sikohinson 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State MAY 1 7 2004 Registrar

			1 = For State Registrar		e of N	larylar		artmen rtificat					Reg. No.	20	04	15	6 4 3
	Physicia /Medic		1. Decedent's Name (First, Midd	Sell w	ran							2. Date of De Month	Day		Yeer COO4	3. Time of 5:54	Death AM
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B	Funeral Director		5. Social Security Number  Usual Residence of Decedent	6. Sex 1 ☐ M 🐉 ☐		36	last birthday Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Mar 14	1 <sup>9</sup> ,1 <sup>9</sup> ,1968		P. Birthpi Coun Ma	lace (State o try) aryland	r Foreign
	Aaryland f show	. [	10a. State 10b. Count  Maryland	y N/A		10c. Cit	ty, Town or L	ocation	Bal	timore					11	0d. Inside Ci	
	with the P a or 28a- Les ricdit	Director	10e. Street and Number 2224 Walbrook Ave					10f. Zip	Code	2121	6		10g. Citi		hat Coun U.S.A.	try?	
036	be filed within 72 hours after death with the Maryland tal Hygiene d other then "natural", or tlems 23a or 28a-f show event, The Micdical Exterior transities indiffed at	by Funeral	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1   If Ye	Decedered Forces Yes 2X s, Give	] No	.S. 13.	Was Dece If Yes, spe		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)	)-		, White,	an Indian, etc. ack	
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Maryland	d ta b	To Be C	17. Father's Name (First, Middle Ch	arles Smith	1					18. Mothe	er's Name	(First, Middle, Ernest					
	1 and 2 sho Health and N Iem 27 Is ma		19a. Informant's Name/Relation Ernestine Spellman	1 1 27 .	")							l Route Numbe e , Maryla			State, Zip	Code)	
Baltimore,	of of or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other		from Stat		Place of Disp cemetery, cre	osition <i>(Nai</i> matory or o Mt. Zio	ther plac	e)		5/13/04			City or To	wn, State Maryland	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	vice Licensee  22. Name and Address of Facility Estep Brothers Funeral Home 1300 Eutaw Place Baltimore, I										17		8	
	Pnysician	i j	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition	st only one cause	on each	tine.	th. Do not en	ter the mod	le of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Bety Onset and D	ween
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ords, P.	The law requires that the site has been signed by the bage 2 should be detache	ted by Ph	Part II. Other significant condi	tions contributing	_	-			-		•	23e. Did t	1			e cause of do	
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Division of Vit	or Attending Physician: The I after death. Director: After this certificate ha in by the funeral director, page	ation; To Be	25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death Datural 5 Pend investigation	Hospital:	Date of Ir (Month, L		ER/Outpatie 28b. Time o Injury		8c. Injury Work	9r: 4□ Nu	ursing Hor	(Check only one 5 Residuel Res	dence (			)	
Divis	To the Hospital or Attanwithin 24 hours after deat To the Funeral Director:	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	minor   200.	Place of I building,	Injury - At h	ome, farm, si	reet, factor	y, office		2	28f. Location (S City or Tox			r or Rural	Route Numi	ber,
	To the Hospital or within 24 hours after To the Funeral Director of completely filled in I	edical	29a. Certifier Certify (Check only 2 Medical one)	ring Physician: al Examiner: On and	o the besthe basis manner	of examina	owledge, dea ation and/or in	rvestigation	, in my op	oinion, dea	nd place, a ith occurre	ed at the time,	date and	place, ar	nd due to	the cause(s)	)
	To the within To the Comple	Σ	29b. Signature and title of certification of the control of the control of the certification	1	Pes	Sidem	- Physi		License	number	52		29d. Dat	e signed	(Month, D	Day, Year)	
_	3		30. Name and address of person	BH MT		22	Som	Print) Gre	cne	Str	ar?	Balmio	e, V	Ŵ.			
	Sta Registr		31. Date filed (Month, Day, Yea	1 7 2004	. 4	strar's Signa		do	× ?								

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Mary	rland / Depa			lental Hyg	iene •g. No.2 (	004	156	544		
Physici	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Dav	Year	3. Time of				
/Medi		Benjamin T.		Saı	nderson		May	10		2004 2:53 a			
Examir	ner	4a. Facility Name (If not institution, give street and number)  Quail Run			4b. City, Town, or Location of Death  Severna Park  last birthday)   If Under 1 Year   If Under 24 Hrs.   8, Date			4c. County of Death					
								Anne Arundel  Birth 9. Birthplace (State or Foreign					
Funeral Director								9. Birthol Coun Mary	Iand	or Horeign			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Integrated the file marked other than "naturel" or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinal match be inclined at once.		10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits				
	tor	MD Anne Arundel Crownsville				Le				1 🗆 Yes	XXNo		
	Funeral Director	10e. Street and Number			10f. Zip Code			0g. Citizen of	f What Coun	try?			
	a D	352 South Riverside Drive				21032			USA				
	ner	11. Marital Status	12. Was Decedent Eve	Was Decedent Ever in U.S. 13.1     Armed Forces?		Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F			14. Race - American Indian, Black, White, etc.				
	by	1 ☐ Never Married 2K Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: W		1 ☐ Yes 2 No Specify:		50		Specify: White				
	Completed	(Specify only highest grade completed) (Give			edent's Usual Occupation a kind of work done during most of working DO NOT use retired)			16b. Kind of Business/Industry					
	E O	Elementary/Secondary (0-12) College (1-4or 5+) 4 Engir			neer			Government					
	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maider				an Sumame)			
	To B	Albert Sanderson Caroli					ne Tallman						
	-	19a. Informant's Name/Relationship (T	vpe, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number	City or Tow	n, State, Zip	Code)			
		Susan Sanderson	(Daughter)	819	Birch Tr	., Crowns	ville, M	$\mathfrak{D}$ 2103	32	-			
		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)							- City or To	wn, State			
Pages nent of ant: If it	1 ,	*A Donation 5 Other (Specify)  Our Lady of the Fields 5/13/2004 Millersville, MD											
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Chensel  22. Name and Address of Facility Hardesty Funeral Home, P.A.  12 Ridgely Avenue, Annapolis, MD 21401											
		23a. Part1. Enter the disease, or comp	ications that caused the	death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	MD 21	Approximat Interval Bet	te		
Pnysician		Immediate Cause (Final Onset and D											
/Medical		disease or condition resulting in death)  Due to (or as a consequence of):											
Examiner				Denedia									
he law requires that the death certificate be executed he law requires that the death certificate be executed a has been signed by the attending physician and age 2 should be detached for use as the burial-transit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):								1		
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
	dlcal	d											
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy  1					23d. Date of delivery Month Day Year					
	hys	9 🗆 Unknown	ari oukuowu										
	by	Part II. Other significant conditions contributing to death but not resulting in the unde				, , , , , , , , , , , , , , , , , , , ,			bacco use contribute to the cause of death? es 2⊠No 3 ☐ Probably 4 ☐Unknown				
	lete				24a. Was a				available				
The law cate has l	Completed						autops perform	ned?	death?	npletion of c 2□ No	ause of		
Physicien: T this certificat al director, pe	(a)	25. Was case referred to medical				26. Place of Deatl					. 1		
	0 0	avaminar?					Home 5 Residence Stother (Specify)						
	n: T	27. Manner of Death	28c. Injury at Work? 28d. Describe how				urred						
	atte	1 Accident 5 Pending investigation		Yes 2□No									
after de Directe	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)			reet, factory, office 28f. Location (S City or Tow			Street and Number or Rural Route Number, vn, State)					
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atter completely filled in by the funerel	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  29a. Certifier (Check only one)  Check only one)  Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Fo the vithin Fo the	Me	Ebb. Digitative and this or sorting.							Date signed (Month, Day, Year)				
~ ^	1	) Mr I	Dros					5.14.04					
1	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MIRZA M. NUSACREE MP: 1667 GLOFTON MEDICAL C-roup, Crofelon.											
		MIRZA M. NUSAIRE	E MP:	1667 Oraf	ITON ME	DICAL GI	Joup, Cr	obron.					
St	ate	31. Date (ligd (Month, Day, Year)	32. Registrar's	Signature	1 .								

			For State Registrar	State of Mary	land / Dep		f Health and	Mental Hyg	giene	004	156	45
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Las Helen     Aa. Fecility Name (If not institution, give	A.	Sc		m, or Location of Dea	2. Date of Dea Month May	Day 10	Year 2004 y of Death	3. Time of Deat	th M
	Funeral Director		Prince Georges Ho  5. Social Security Number  440–18–8726  Usual Residence of Decedent	7. Age (Ir	yrs. last birthday 88 Yrs.	) If Under 1 Y	erly  ear If Under 24 Hrs  ays Hours Min		h	9. Birthpl Count Illi	rges ece (State or For ry) nois	reign
	be filed within 72 hours after death with the Maryland all Hygiene. It Hygiene. Id other than "natural", or items 23a or 28a-f ahow avant, the Medical Examiner must be notified at	by Funeral Director	10a. State 10b. County	Georges		10f. Zip Co	de 20721 of Hispanic Origin? (! Cuban, Mexican, Puer		10g. Citizen of  USA  14. Ra  Bla  Speci	What Count  A  ce - America ack, White, e	an Indian,	
7	d be filed within 72 hou intal Hygiene. ted other than "natura c avant, the Medical E	Be Completed	15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Homer J. Smith	ucation	(Giv life.	edent's Usual O e kind of work d DO NOT use re	one during most of wo atired)  18. Mother's Na			overnm		
e, mar	ages 1 and 2 should be intof Health and Mental It: If Item 27 Is merked o y or other treumatic avs	To	19a. Informant's Nama/Relationship (7  Paul Schaub, Jr.  20a. Method of Disposition  1 Burial Accremation 3 1  4 Donation 5 Other (Specify	(Husband) Removal from State		Lottsf  consistion (Name of other or other	ord Road,  f place)	#437, Mi	r, City or Town	ville,	MD 2072 vn, State	21
Baitir	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licen	500		Name and A Hardes 12 Rid	dress of Facility ty Funeral gely Avenu	l Home, P	.A. olis, 1		01	
/60,	Physician Jude be executed by Jude ical by Jude ical Examiner	ical Examiner	23a Part1. Enter the / ise / ise / ise only of shoot or heart failure. List only of in rediate Cause (in disease of condition resulting in death)  Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Chronic  Due to (or as a co	Respirat onsequence of): Obstruct onsequence of):	ory Ins	ufficiency monary Dis				Approximate Interval Between Onset and Death	
O. Box 68	death certif e attending ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 TaNo 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregn □ Other (specify			1	ate of deliver	y Day Year	
7.	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions or Diabetes Mellit		ot resulting in the	underlying causi	e given in Part I.		bacco use con		e cause of death	
Vital Records,	The lar ate has page 2	Completed							sy med? 2 <b>X</b> No	Were autop prior to com death? 1 Yes	sy findings availa ipletion of cause 2 No	able of
o C	ing Phys Mer this uneral di	Certification: To Be	27. Manner of Death  10 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye		of 28c.	Other: 4 Nursing I Injury at Work? 1 Yes 2 No	ath (Check only or Home 5 Resid 28d. Describe h	ence 6 Oti ow injury occu	rred		
ī	To the Hospitel or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the ti	edical Certi	29a. Certifying Ph	building, etc. (5 ysicien: To the best of m iner: On the basis of exa	pecify) y knowledge, dea	ith occurred at If	ne time, date and plac	e, and due to the curred at the time, d	ause(s) and m	anner as sta	ited. the cause(s)	
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated		DU	tense number +2049	ľ	29d. Date signed	od (Month, D	2004	
	Sta Registi		Alain G Champa  31. Date filed (Month, Day, Year)  MAY 1 7 2004	loux, MD Up	per Marl	boto, M	D 20772					

State of Maryland / Department of Health and Mental Hygiene 200415646 1 - State Registra Certificate of Death Name (First, Middle, Last 2. Date of Death **Physician** /Medical 4c. County of De Examiner If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) **Funeral** Days Months Hours 12M 20F Director death with the Maryland 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be motified at 1 Yes 2 □ No Completed by Funeral Director Citizen 6 of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, letc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of condary (0-12) College 4or 5+) OX To Be nt of Health a t: If item 27 Is y or other tre ed of Disposition 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** iveel disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 🗆 No 3 Probably 4 Unknown ector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 A No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 3□ DQA 2 1 🗌 Yes 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 🗌 No death. 2 Accident Director: 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 - Homicide Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number Lao 1 an an 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE STE 107 RAO 3333 CALVERT 31. Date filed (Month, Day, Year) State 1 7 2004 Registrar

			For State	State of Ma	ryland / Dep	artment of	Health and	Mental Hy	giene	
_			Registrar		Ce	rtificate of	Deam			04 15647
	Physici	ian	Decedent's Name (First, Middle, Las.					2. Date of Dea Month		3. Time of Death
	/Media		ETHEL		RUTH	SHOCK	EI.	MRY		7:30 4M
	Examir		4a. Fecility Name (If not institution, give	street and number)			or Location of Dea		4c. County of	f Deeth
			Sinai Hospit	2/		Balti	more,	MD		N/A
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday	Il Under 1 Year		8. Date of Birth	h Vaari	Birthplace (State or Foreign Country)
	Director	1	212-36-3836	□M 217 F	93 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day JAN. 29	1911	MD
	0		Usual Residence of Decedent						,	
	ylan how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mar	jo	MD BALTI	MORE	BAL1	IMORE				1 ☐ Yes 2 No
	28 2	ē	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	hat Country?
	De liled within 72 nouts after death with the Maryland nial Hygiene. Ad other then "natural", or Items 23e or 28e-f ehow event, the Madical Examinal mist be notified at	Funeral Director	6514 SANZO ROAD	#A			21209			U.S.A.
	18 2 E	era	11. Marital Status	12. Was Decedent Ex	ver in U.S. 13	Was Decedent of		Specify Ves or No-	14 Page	- American Indian,
_	le le le le le le le le le le le le le l	5	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cui	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Black	, White, etc.
2	2	b	3 X Widowed 4 Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specity:	WHITE
ξ.	non fura		15. Decedent's Edu		16a Deco	ident's Usual Occu	unation		16b. Kind ol Bus	in a call a decade
ם ו	a de de	et		le completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking	160. Kind of Bus	iness/industry
7	then.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		MAKER	50)		OWN HOME	
<b>V</b>	Hygic her h.		17. Father's Name (First, Middle, Last)		HOME	.IIAKLK	10 Markada Na	- (Final Middle		
=	d la b	Be			DDE1	CCMAN		me (First, Middle,	Maiden Sumame	
2	snould by	ို	HARRY			SSMAN	CECEL			PAUL
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (T)				t and Number or Ri			
<u>.</u>	and Balth In 27		HARRIET COOPER /	DAUGHTER	6933	B-B CLEAR	WING COUP	RT - BALT	IMORE, N	ND 21209
D .	of Head		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pla	ace)	Date	20c. Location - C	ity or Town, State
Daltillion	ant of		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			IEMORIAL		4/2004	DANDALL	CTOUN MD
	industria.		21. Signature of Funeral Service Licens			2. Name and Addr				STOWN, MD
0	permit. Pages Department of h Important: If its any injury or of once.		· Chened	Must /			50			S., INC.
			200 Part Col	VIIIV						E, MD 21208
			23a. Part1. Enter the disease, or comp shock, or heart lailure. List only o	ne cause on each line					est,	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	Cun	gestive	Heart	Failu	56		Onset and Death
	/Medical		resulting in death)		consequence of):					
٠,	Examiner		Constitute that are stated							
ш.	3 6	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
	d d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events							
	al-tr	Examiner	resulting in death) Last	Due to (or as a	consequence of):					
<b>S</b> .	ate be executed by sicion and the burial-transit	cai								
ō ·	phys the			d						
9 4	ding se as	Me	IF FEMALE:	22- 11						
	ttenc or us	an	23b. Was decedent pregnant in the past 12 months?	3c. II yes, outcome of 1 ☐Live birth 2		□Ectopic pregnanc	:y		23d. Date Monti	
	he a	Sic	1 □ Yes 2 No	4☐Pregnant at tir 9☐ Unknown	ne of death 5[	Other (specify)			WORK	Day Teal
	by t	Physician/Medi	9 Unknown							
n i	as in	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ה ה	on sig	Pa						1 🗆 Y	es 2112/No 3	Probably 4 Unknown
3	sho sho	Completed						24a. Was a	n 24h Wa	ere autopsy lindings available
ב ו	a has	E						autops	SY Drie	or to completion of cause of
<b>5</b>	cate r, pa							1 ☐ Yes	2 No 1 E	Yes 2 No
	Becton	Be	25. Was case referred to medical examiner?	ta a mita la				ath (Check only on	(8)	
8	his o	2	1 ☐ Yes 20X No	lospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA Ot	her: 4 Nursing H	lome 5 Reside	ence 6 Other	(Specify)
	fter t	ü	27. Manner of Death  N⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Time of Injury	f 28c. Inju Wo	ry at rk?	28d. Describe ho	ow injury occurred	
2	ath.	atic	2 Accident investigation				Yes 2 □ No			
	er de ecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, larm, st	reet, factory, office		28l. Location (St	reet and Number	or Rural Route Number,
5	d in die	eri	4 I Homode	building, etc.	(Specify)			City or Town	n, State)	
1	spurs lours nera		29a. Certifier 16 Certifying Phy	sician: To the best of	my knowledge, deat	h occurred at the ti	me, date and place	, and due to the c	ause(s) and mann	ner as stated
d	24 h P Fun etely	edical	(Check only 2 Medicel Exemi	ner: On the basis of e	xamination and/or in	vestigation, in my	opinion, death occu	rred at the time, d	ate and place, an	d due to the cause(s)
	To the troughlator when the families of the taw requires that the death certificate.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature apertitie of certifier			29c. Licens	se number	2	9d Date signed /	Month, Day, Year)
ŀ	- 3 <del>-</del> 8		1	9/1=	MN					
	1				1.0		5-000	(	May 1	1,2004
	4		30. Name and address of person who co		-		1 1 1	0.	1.0	
			3	akefield	M.D.	Sina: 1-	tospital	,1501.	FMORE	MD
	Sta		31. Date filed (Month, Day, Year) MAY 1 7 2004	32. Registrar'	s Signature		1			7
	Registr	7.7	19121 T 1 7 77110 A	/a		-				

as shocket

Patient Known

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.1

		1	For State Registrar	State of Ma	tryland / L	oepa Cer	irtment of F tificate of i	ieaith and i Death		giene Reg. No		15648
Phys	iciar		1. Decedent's Name (First, Middle, Las	t)		5	card	ina	2. Date of De Month		y Year	3. Time of Death
/Me Exan			4a. Facility Name (If not institution, give	street and number)				r Location of Death	105	4c.	2009 County of Death	
			Loch Raven VA Re					timore			N/A	
Funer: Directo	_		217-40-9903	7. Age XIM 2□F	60	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar. 1	$\stackrel{\text{th}}{1}$ , $\stackrel{\text{Year}}{1}$	9. Birth Cou L944 Ma	place (State or Foreign ntry) aryland
yland now		-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation	-				10d. Inside City Limits
Ba-f st		2010	MD N/A				Baltimo	re		_		1X Yes 2 □ No
with th	2	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	ntry?
death ma 23	1	era	781 West Cross St:	12. Was Decedent 8	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	L230 ispanic Origin? (S	pecify Yes or No	Un -	ited Sta	
DEALLIMOTE; INICITY STATES AND SO DEALLY PROPERTY. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, to the Madical Exercities Investice rights of an individual.	1	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ₩ iovorced	Armed Forces?  1.  Yes 2 □ N  tf Yes, Give  Year or Dates:4		1	Yes, specify Cuba		o Rican, etc.)		Black, White,	
72 hc	1	ered	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a.	(Give	ent's Usual Occup	during most of wor	king	16b. K	ind of Business/Ir	ndustry
within iene.		Сотріете	Elementary/Secondary (0-12)	College (1-4or 5	+)		isabled	0	-		N/A	
al Hyg		9 -	17. Father's Name (First, Middle, Last)				ISADIEU	18. Mother's Nan	ne (First, Middle	Maiden		
ylar hould be t Menta narked natic ev			Vincent F. Scardin						nine M.			
Mal of 2 sh th and th and 27 is m traum			19a. Informant's Name/Relationship (7)				g Address (Street					
theal item 2			Christopher Scard: 20a. Method of Disposition		20b. Place of	Dispos	N. Fairfa		Arlin Date	20c. Lo	ocation - City or T	.03 own, State
Page ment o ant: If ury or		1	1 Surial 2 Cremation 3 C		MD Vet		natory or other place ns Cemete ille	<sup>g</sup> ry   5−17	-2004	Cro	wnsville	, MD
permit. Pages Department of Important: If it any injury or or	once	(	21. Signature of Funeral Service Cicer	Olberti	61381	22.	Name and Addres			ral	Homeof L	ansdowne
-47			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. Do r							Approximate Interval Between
Physicia /Medica	_		Immediate Cause (Final disease or condition resulting in death)	a. Me	tusta	21	ic rec	ual	canc	e-		Onset and Death
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To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours attendeath.  To the Funaral Director: Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Incinion		23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of the first state of the fir	2 Fetal death		Ectopic pregnancy Other (specify)			2	23d. Date of deliv Month	ery Day Year
s that		Dy P.	Part II. Other significant conditions co	entributing to death bu	it not resulting in	the un	derlying cause give	en in Part I.	23e. Did t	obacco u	use contribute to t	he cause of death?
require sen sig									1 🗀 '	/es 2(	XNo 3 ☐ Prot	pably 4 Unknown
ding Physician: The law Ind.  After this certificate has be tuneral director, page 2 st	omojo	completed							24a. Was autor perfo 1 🗆 Yes		prior to co	psy findings available mpletion of cause of 2 No
vite siclan certifi irector	α	ם כ	25. Was case referred to medical examiner?	Hospital:			3□ DOA Cthe	26. Place of Dea				
g Phys		- 1	27. Manner of Death	28a. Date of Injur	y 28b. T	ime of	28c. Injury	at Yoursing H	ome 5 Residente l		6 □Other (Specif ry occurred	y)
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ital or Att rs after de ral Diracts	Cortification		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of tnju building, etc	ry - At home, far . <i>(Specify)</i>	m, stre	et, factory, office		28f. Location (3 City or Tox	Street and vn, State	d Number or Rura )	al Route Number,
To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	iodipo	200	29a. Certifier  (Check only one)  1	rsicien: To the best of iner: On the basis of and manner sta	examination and	, death Vor inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the rred at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
To To con	N	2	29b. Signature and title of certifier	omei /	y. D		29c. License				te signed (Month, $5/13/2$	
8			30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (	Type, F	Print) Blud	· Balt	rusie	М.	D 212	810
Regi:	State strai		31. Date filed (Month, Day, Year)  MAY 1 5 2004	32. Registra	r's Signature	lore	E g					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 2004 **Physician** 9:45P HELEN ELIZABETH UNDERWOOD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Jarrettsville Harford Modonna Heritage If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Director 219-10-6650 78 11/30/1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show reumetic evant, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Jarrettsville Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 3519 Advocate Hill Drive 21084 U.S.A. Itams 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Grauling Victoria Rykowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an nt of Health : Cheryl Chavis P.O. Box 630 - Fallston, Maryland other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ō Department of Importent: If any injury or once. Highview Memorial Gdns.05/15/2004 Fallston, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 as 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebra Pnysician ascular /Medical Due to (or as a consequence of): **Examiner** oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequi-Be Completed by Physician/Medical Examiner ongestiv the burial-transit The law requires that the death certificate be execut Due to (or as a consequence of): Box 68760. as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown for 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ **X** lo ertension 3 Probably 4 Unknown Nyastenia 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes ☐ Yes 24 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Vivising Home 5 - Residence 1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide þ determined 4 T Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar S. Knich

MAY 1 7 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

#102

Physic	ian	1. Decedent's Nam		State m #23a			Certin	icate of	Dealli	2. Date of D			Year	3. Time of Death
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Physicia /Medic Examin	al .	4a. Facility Name (If not institution, give s	s NURSING HO	OME	BA	or Location of I	MAY 1	4,2	County of Death	N/A
Funeral Director		Usual Residence of Decedent	м ж 80′	Yrs.	If Under 1 Yea Months Days		8. Date of Bi Min. (Month, Di SEPT.	17,		nplace (State or Foreign untry) VIRGINIA
the Marylan 28e-f show otified at	Director	MD • 10b. County N/A		Town or Lo				10a Cit	tizen of What Cou	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
be filed within 72 hours after death with the Maryland all Hygiene.  de Hygiene.  de other than "natural", or items 23e or 28e-f show avant, the Medical Examinar must be notified at	by Funeral Dir	4011 PARKWOOD	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No	'	Was Decedent of t Yes, specify Cu	1206 Hispanic Origin Iban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		Hace - Arrei Black, White	ricar Indian,
ithin 72 hours a ne. nen "neturel", c Med fall Exam	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	If Yes, Give 12 Year or Dates: cation completed) College (1-4or 5+)	16a. Dece (Give life.	1 ☐ Yes 2 Note Note No. 1 ☐ Yes 2 No. 1 ☐ Yes 2 ☐ Yes 2 ☐ Yes	upation e during most o red)	f working		Specify:	ndustry
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Pnysician /Medical Examiner	2 h	disease or condition resulting in death)	e cause on each line.  Due to (or as a consequence)	Sno	1		hima			Interval Between Onset and Death
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_ ~	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)		eet, factory, office	Э	28f. Location ( City or To	wn, State	)	ral Route Number,
To the Hospital or within 24 hours affer To the Funerel Discompletely filled in	Medical		ician: To the best of my knowner: On the basis of examination and manner stated.		estigation, in my			date and		to the cause(s)  Day, Year)
2		30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person address of person and address of person addre	mpleted cause of death (Item 22)	N.	Print) Enta	w 81	- onte			lf. moliza
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ONNIE MAE WALLACE 10:20 PM 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAY FARE ROAD BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 77 Director 220-20-5699 11/16/1926 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Modical Exeminat must be notified at 1 Yes 2 No Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3115 Mayfair Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🔀 No Specity: **Black** 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be f and Mental F John Robert Carr Jimma Persall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 Is n any injury or other traun 3807 West Rogers Ave., Baltimore, Maryland 21215 ce of Disposition (Name of Date 20c. Location - City or Town, State Laura Wheeler / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) n Cemetery 05/22/2004 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. Woodlawn Cemetery 21. Signature of Funeral Service License once. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List onty one cause on each line. Immediate Cause (Final disease or condition resulting in death) CELL (ARCINOMA KENAL **Physician** 6 MOS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner attending physician and I for use as the burial-transit certificate be executed Exam Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 ANo
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year signed by the and to be detached to 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, HYPERPALATHYROIDISM cate has been sig 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) After this confunction 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 1 A Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Yeer) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending To the Hospital or Attending Within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060286 : IND who completed cause of death (Item 23a) (Type, Print) 401 N. BROADWAY BALTIMORE, MD 2/23/ 32 Registral's Signapare State Registrar

Dhamis		1. Decedent's Name (First, Middle, Last		• • • • • • • • • • • • • • • • • • • •	2.	Date of Death Month Da	3. Time of Death	-
Physicia /Medic			Robert Lee W		) [	May 1	0' 900H 900b	1
Examin	er	4a. Facility Name (If not institution, give	eral Hos	prial Baltin	or Location of Death	4	c. County of Death  N/A  9. Birthplace (State or Foreig	
Funeral Director			<sup>□M 2□F</sup> 67	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Year, Jun 18, 1930	6 Country) SC.	
and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limit	s
/z nours arier beam win ne Maryano natural', or Items 23a or 28a-1 show Rical Examiner must be notified at	tor	Maryland N/	4	В	altimore		Yes 2 No	5
st be not	Funeral Director	10e. Street and Number 1529 Druid Hill Ave.		10f. Zip Code	21217	10g. Ci	itizen of What Country? U.S.A.	
itam 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cult	Hispanic Origin? (Specify ban, Mexican, Puerto Rican Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
Medical E	Completed	15. Decedent's Edu (Specify only highest grad		life. DO NOT use retire	e during most of working ed)		Gind of Business/Industry hemetals Chemical Co.	
aumatic event, the Ma	Be	12 17. Father's Name (First, Middle, Last) Willie Wit	nerenoon	Machin	ne Operator  18. Mother's Name (Fi	irst, Middle, Maidei Julia Bla		
traumatic	၉	19a. Informant's Name/Relationship (T) Ethel Witherspoon		19b. Mailing Address (Stree 1529 Druid Hill	ot and Number or Rural Ro I Ave. Baltimore, N	oute Number, City	or Town, State, Zip Code)	
Important: If itam 27 any injury or other tr once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	lace of Disposition (Name of emetery, crematory or other planets Western Cemet	04/		ocation - City or Town, State Baltimore , Maryland	
Important: If any injury or once.		21. Signature of Funeral Service Licens	ee at	22. Name and Addr Estep E 1300 E	ress of Facility Brothers Funeral H utaw Place Baltin	lome P.A. nore, MD 212	217	
/sician ledical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a.	e multipl	ring, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death	
am physician and surial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	nal Fa	le my	elma	
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n signed by uld be detac		Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying cause g	iven in Part I.	23e. Did tobacco	use contribute to the cause of death? :□No 3□Probably 4☑√nknow	n
cate has been si	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	Θ
is certificate director, pag	o Be	25. Was case referred to medical examiner?	fospital:	ER/Outpatient 3□ DOA C	26. Place of Death (C		6 ☐Other (Specify)	
After th funeral	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo	(2) (S/2) (1)	Describe how inju		
	tifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f.	Location (Street as City or Town, State	nd Number or Rural Route Number, e)	
al Directo ed in by th	Cer		V	wiedne death occurred at the t	time date and place and	due to the cause(s	s) and manner as stated.	
he Funeral Directo		29a. Certifier (Check only one) 1	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or investigation, in my	opinion, death occurred a	it the time, date an	d place, and due to the cause(s)	
To the Funeral Director: completely filled in by the	Medical Ceri	(Check only one)  2 Medical Exam  29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	tion and/or investigation, in my	opinion, death occurred a		ate signed (Month, Day, Year)	-
within 24 hours after death  To the Funeral Director: A  completely filled in by the fi		(Check only one)  2 Medical Exam  29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	tion and/or investigation, in my	opinion, death occurred a			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68750,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ician		1. Decedent's Nam Paul		tze∮, Jr					2. Date of Month	Day	Year	3. Time of Death
dical niner		la. Facility Name (					4b. City, Town	, or Location of			ounty of Death	
		3829 Ma	ry Aven	ue				altimore	-	N	I/A	
al or	2	5. Social Security N 214-74-96 Usual Residence of	87	6. Sex 1☐ M 2☐ F	7. Age ( <i>In yr</i> s. 48	last birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 2 /s Hours	8. Date of (Month, June)	Birth Day, Year) 24,195	9. Birth Cou 5 Mar	pplace (State or Foreig intry) yland
	-	10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limit
io.	2	MD	N/A	1	į į	Baltimo	ore					1 X Yes 2 □ N
I Director		10e. Street and Nu 3829 Mar		ıe			10f. Zip Cod			10g. Citizer	of What Cou	untry?
by Funeral		11. Marital Status 1 □XNever Marr 3 □ Widowed		Armed F	2 □ No ive	'	Was Decedent of Yes, specify C	uban, Mexican,	jin? (Specify Yes or Puerto Rican, etc.)		Race - Amer Black, White	
ed		5 E 771d0710d	15. Decedent		Jaies.	16a. Deced	dent's Usual Oc	cupation		16b. Kind	of Business/li	
once.  To Be Completed by Funeral Director		(Spec	cify only highes	College (		(Give	kind of work do DO NOT use ref neral Ma	ne during most ired)	of working		Servi	,
o Be C	3	17. Father's Name		zel, Sr.				18. Mother	's Name (First, Midd ginia Lee		mame)	
		19a. Informant's N Paul R.		ip (Type, Print)	Father		-		r or Rural Route Num . H Baltin	-		
	2	20a. Method of Dis				Place of Dispo	sition (Name of natory or other p	olace)	Date	20c. Locat	ion - City or T	own, State
		1 M Burial 2 4 ☐ Donation		3 □Removal from ecify)	State	•	Cemete		/17/04	Balti	more,	Maryland
once		21. Signature of Fu	uneral Service L	icensee Heat	her Cai				Leonard			
dical Examiner		Sequentially list co if any leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	nmediate erlying injury	b. Due to	(or as a conseq	uence of):						
Physician/Media	)	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 { 9 ☐ Unknown	months? ⊒No	1 Live	itcome of pregna birth 2 ☐ Feta nant at time of d nown	Ideath 3⊑	Ectopic pregna Other (specify)			23d	. Date of delive Month	rery Day Year
2	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other signi	ficant condition	ns contributing to o	leath but not resi	ulting in the ur	nderlying cause	given in Part I.		d tobacco use		the cause of death?
e Completed		05 W							1 Yes	topsy rformed? 2 \( \text{No} \)	4b. Were autoprior to codeath?	opsy findings available ompletion of cause of
o Be	1	25. Was case refer examiner?  **EXYes 2:		Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	1ther	of Death <i>(Check onl</i> sing Home 5 🔀 Re		Other (Special	·64)
I	1	27. Manner of Deat 1 ☐ Natural	th 5 🗌 Pending		of Injury 1th, Day Year) 5/13/04	28b. Time of Injury	28c. lr		28d. Describ	e how injury of		197
Certification:		2 Accident 3 Suicide 4 Homicide	investig. 6 ( <b>X</b> Could n determin	ot be ned 28e. Place build	e of Injury - At ho ling, etc. (Specify at home				28f. Location City or 7	(Street and N rown, State)		al Route Number,
		29a. Certifier (Check only one)		xaminer: On the b					place, and due to the connection occurred at the time	e cause(s) and	d manner as s	stated.
Ö		29b. Signature and	I title of certifier				29c. Lice	nse number		29d. Date si	igned (Month,	Day, Year)
Medical		electro		1 000 //	- H200	2 line	$\propto$	ME		May 1	4, 200	4

		4	1 - For State of Maryland Registrar		artment of H			iene <sub>eg. No.</sub> 20 (	15655
	g		Decedent's Name (First, Middle, Last)	<del></del>			2. Date of Dea Month	th	3. Time of Death
	Physicia /Medic		Jennie Z	ylwiti	İs		May		04 2:15 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	Death
			1348 Governors Bridge Road			onville			e Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6/29/19	Year)	9. Birthplace (State or Foreign Country) PA
· ·	Director		Usual Residence of Decedent				0/29/13	710	ra
	yland yland		10a. State 10b. County 10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fst	ctor	Maryland Anne Arundel Da	vidson	ville				1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	ath w		1348 Governor Bridge Road		21035	0 : . 0 /0	- 4 . V N		J.S.A.
	ltems	Funerai	11. Marital Status  12. Was Decedent Ever in U. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1. ☐ Yes 2 ☑ No	5. 13. 1	was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	Aican, etc.)		White, etc.
36	irs aft	by	3X Widowed 4 Divorced Year or Dates:	-	I□Yes 2¶ No	Specify:		Specify:	White
Š	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jical Examiner must be mailfied a		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ient's Usual Occup	ation during most of work	ina	16b. Kind of Bus	ness/Industry
21215-0036	within 7 lene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired	1)	9	C. 11. W.	:11_
12	be filed within 72 hours after death with the Marylan deathly giane.  del Hygiane.  del char than "natural; or Items 23a or 28a-f show and. Ite Modical Examiner must be multiped at event.		17. Father's Name (First, Middle, Last)	Seams	tress	18. Mother's Name	a (First Middle	Silk M:	
Maryland		Be	Francesco Rich			Anna Bo		maiddir garranio,	
Z	# DEE	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura		r, City or Town, S	tate, Zip Code)
	ha ha		Francis Zylwitis (Son)	1348	Governo	r Bridge	Rd. Davi	ldsonvil	Le, MD 21035
altimore,	s 1 and of Healt itam 2 r other		20a. Method of Disposition 20b. P	lace of Dispo	sition (Name of natory or other place	(9:	Date	20c. Location - C	ity or Town, State
<u>m</u>	Pages nent of I ant: If its ury or o		1 ∠Burial 2 □ Cremation 3 □ Hermoval from State  1 □ Donation 5 □ Other (Specify)	ly Sav	iour	5/18	/2004	Bethlehe	em, PA
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	22	Name and Address Hardesty 12 Ridge	ss of Facility Funeral 1y Avenue	Home, P	.A. olis. MD	21401
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	80 V as	1.0		dent		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence)	uence of):					
	LXdillillei	<u>L</u>	Sequentially list conditions, b. Due to (or as a consequent	ence on					
	red nsit	nine	cause. Enter Underlying Cause (Disease or injury	33					
Ć.	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of the cons	uence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		d						
68	ng ph as th	Medi	IF FEMALE:						
Вох	leath certifica attending ph I for use as th	an/l	23b. Was decedent pregnant in the past 12 months 23c. If yes, outcome or pregna	death 3	Ectopic pregnancy	1		23d. Date Mont	
O.E	the at	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 5	Other (specify)			171371	
P.0	that the de ned by the a detached		Part II. Other significant conditions contributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
Records,	uires tha signed l	d by	Eoronary Arkery Dice	482	Dick	etes,	1 □ Y	es 2 10 3	Probably 4 Unknown
COL	w requir been si should	iete	Hyporbension			,	24a. Was a	an 24b. W	ere autopsy findings available
Œ	0 4	Completed	Thy private in				autop: perfor	med? de	or to completion of cause of ath? ☐ Yes 2☐ No
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Deatl			163 2010
	S D	To B	examiner? 1   Yes 2   Hospital: 1   Inpatient 2	EP/Outpatier	it 3□ DOA Oth	er: 4 🗆 Nursing Ho	me 5 D msid	ence 6 Other	(Specify)
n of	ng Pł fter tł meral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe h	ow injury occurred	t .
Sio	Attanding or death.  actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No	28f Location (S	traat and Number	or Rural Route Number,
Division	or All after of Dirac in by	Certification:	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specifi	/)	eet, factory, office		City or Tow		or rurar routs rumsor,
	spital ours narai		29a. Certifier 1 Certifying Physician: To the best of my kno						
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occur	red at the time, d	late and place, ar	d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	er.	29c. Licens	e number	7 3	29d. Date signed	(Month, Day, Year)
	1		· Stell-1-17	mp	V	2068	7	5119	12007
	V		30. Name and address of person who completed cause of death (Item	23a) (Type	Print)	m RA.	Spil	2100	ack MD
	Sta	ate	31. Date filed (Month, Day, Year) 32. Degistrar's Signa	ture /	10 NIIIO	1110		1700	131146
**	Regist		MAY 1 7 2004 Same	B	Sparks				

			1 - For State Ragistrar	State of Marylan		nt of Health and I te of Death	Mental Hygier	/ 111111	15656
£	Physici /Medio	al	1. Decedent's Name (First, Middle, Last  One++q  4a. Fecility Name (If not institution, give	AII	en 4h Git	y, Town, or Location of Death	3	Day Year 2004	3. Time of Death
-44 -44 -45	Examir Funeral Director	ier	University of Mas 5. Social Security Number 6. Se 214-42-8832	yland Medical	1 Cntr	Baltimore eriyear If Under 24 Hrs.	8. Date of Birth (Month, Day, Yes	9. Birthp	place (State or Foreign htry)
2-0036 CLCS	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Items 23e or 28e-1 show with the Madical Exercities It was the inclined at	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Tollocounty  10e. Street and Number  Soldon Arcadio  11. Marital Status  1 Prover Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edit (Specify only highest grace)	2 Street  12. Was Decedent Ever in U. Armed Forces? 1 □ Yes. 2 ☑ No If Yes. Give Year or Dates:	S. 13. Was Dec If Yes, sp	ip Code  2/60   edent of Hispanic Origin? (S) ecify Cuban, Mexican, Puert 2/8 No Specify:  ual Occupation rork done during most of wor use retired)	pecify Yes or No- o Rican, etc.)	Citizen of What Cour  U.S.A  14. Race - Americ Black, White, Specify: Black Kind of Business/In	can Indian, etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show my injury or other traumatic event, the Madical Exacilist Iransi ke inclined at once.	To Be Comple	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Russell  19a. Informant's Name/Relationship (7)  20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify  21. Signature of Funeral Service License	College (1-4or 5+)  Cland  A  Type, Print)  Cland  A  Permoval from State  College (1-4or 5+)	19b. Mailing Addre  803-And Place of Disposition (Nemetery, crematory on hard's Menu	18. Mother's Nan  18. Mother's Nan  Margal  ss (Street and Number or Ru  ame of other place)  Park 5/	ne (First, Middle, Maid ref Mar ral Route Number, Cit 25 to v, Mar Date 200,	ie SKi y or Town, State, Zip Cyland L cation - City or To 1 Stow Ma	(2 Code) 21 (c (2 / own, State
	Pnysicial and Medical Examine phasicial and	lical Examiner	23a. Part. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list or ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to or or or or or or or or or or or or or	Are try uence of):  UICERS uence of):	1	or respiratory arrest.	lge, MD	Approximate Interval Between Onset and Death
.O. Box 6	at the death certifica by the attending pt tached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	I death 3 Ectopic			23d. Date of delive Month	ery Day Year
<b>Q</b>	w requires that the bear signed by should be detact	by	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	cause given in Part I.		o use contribute to the	
al Records,	The ate h page	e Completed	25. Was case referred to medical					?   death?	psy findings available impletion of cause of 2 No
Division of Vital	ding Phys J. After this funeral dir	Certification; To Be	examiner?	Hospital: Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	OOA Other: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No	ome 5 Residence 28d. Describe how in	jury occurred	
Divi	i ji fe		4 Homicide determined  29a. Certifier Certifying Phy	building, etc. (Specify	y) wledge, death occurre	d at the time, date and place	28f. Location (Street City or Town, St	ate) (s) and manner as si	tated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	23a) (Type, Print)	9c. License number	29d. I	Date signed (Month,	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signe		edical Ce	nter		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** John Edward Brittingham April 30, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Director 216-14-9013 MD Sept. 5 1923 80 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23a or 28a-1 ehov any injury or other traumatic avent, the Modical Examiner must be notified at angles. MD Worcester Berlin 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8937 Nine Pin Branch Rd. 21811 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Types 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Specify: White þ 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Heavy Equipment Operator County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Brittingham Jenny Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Brittingham 8124 Shire Dr., Berlin, Md. 21811 of Disposition (Name of 20c. Loca 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery 5-2-04 Libertytown, Maryland 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Fundral Service Licensee 108 William St., Berlin, Maryland 21811 23a. Part1. Enter the disease, or complications at caused the shock, of heart failure. List only one cares on each line. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 0 Vasau Due to (or as a consequence of). cian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the infuneral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 💥 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060535 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Nadia Angov, M.D. 9733 Healthway Dr., Berlin, Md. 21811 31. Date filed (Month, Day, Year) State APR 3 0 2004 Registrar

DHMH 17 Rev 1/2001

John Brittingham

		riease	Chata of Manual				•	_	
		1 _ State	State of Maryla		artment of Health		ental Hygle	ne 200L	15658
		Registrar		Cei	rtificate of Death		Reg.	No.CUUL	
Physi	cian	Decedent's Name (First, Middle, L	ast)	a .	1	2	2. Date of Death Month	Day Year	3. Time of Death
/Med		Earie	ETTa	pai	184		APRil 2	8, 200	
Exam	iner	4a. Facility Name (If not institution, g	. /	ı	4b City, Town, or Location	of Death		4c. County of Dea	
		Easton Memor			Eastow			Talbot	
Funera		4: 0- 0-	Sex 7. Age (In y	rrs. last birthday)  2 Yrs.	If Under 1 Year If Under Months Days Hours		B. Date of Birth (Month, Day, Ye	ar) 9. Bi	rthplace (State or Foreign ountry)
Directo	r	Usual Residence of Decedent	6	9		F	tfril 11,1	941 M	aryland
land bw		10a. State 10b. County	10c.	City, Town or Lo	cation	-			10d. Inside City Limits
f sh	ō	MD Talb	n+	Trai	000				1 ☐ Yes 2 12 No
the the	Director	10e. Street and Number	<u> </u>	114	10f. Zip Code		10g.	Citizen of What C	ountry?
3a ou	Ö	6744 012	TRappe Ro	101	2/672	2		11< A	•
U36  ours after death with the Maryland raft, or Items 23a or 28e-f show Examinat must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hispanic Or f Yes, specify Cuban, Mexica	rigin? (Speci	ify Yes or No-	14. Race - Am	
after or Its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				can, etc.)	Black, Whi	
-UU36 hours after tural, or ite	<u>\$</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:	/:		Specify: BI	ack
	Completed	15. Decedent's l (Specify only highest g		16a. Dece	dent's Usual Occupation kind of work done during mos	st of working	16b	. Kind of Business	
d within 72 giene.	현	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		100	4	,
N 8 5 6	S			ASSEN	ably Line V	NorKe	First, Middle, Maid	anufac	turing
and d be fift antal Hy ced oth	æ	17. Father's Name (First, Middle, Las			1				J
YIS	2		razier	1		ulir		een	
Mar 12 sh 14 and 18 m 7 Is m traum		19a. Informant's Name/Relationship	0 11	19b. Mailir	ng Address (Street and Numb		4 4		W
re, n s 1 and f Health item 27 other t		Ernest Lewis	5 Bailey	_624		ROQC Dat	1-trapp		and 2/673
MOre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	\	natory or other place)	-/	/	Location - City or	
Pages ment of tent: If i		*4 □ Donation 5 □ Other (Spec			cometery!	3/05	104 TV	Rappe, N	lary land
Departition of the popular in the po		21. Signature of Funeral Service Lice	ensee	2 11	Name and Address of Facili	MOHI	e	1	211:0
	Ol .	- Chiell	a C. Henre	/ 6	in Moshiniator	N >+.1	' a wibici o	lege, MI	
		23a. Part1. Enter the disease, or con shock, or neart failure. List only	mplications that caused the d ly one cause on each line.	th. Do not ent	er the mode of dying, such as	s cerdiac or r	respiratory arrest,	0/	Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition			cordial fufo				2 hours
/Medica		resulting in death)	Due paloi as a cons	oddagilog oil.	0				San See See
Examine		Sequentially list conditions,	b	idesis					Jeans
od it	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of).					
ecute and trans	Cam	that initiated events resulting in death) Last	C. Due to for see a con-						
/ <b>bU,</b> e be executed rsician and e burial-transit			Due to (or as a cons	sequence or).					
	dlcal		d						
	Physician/Med	IF FEMALE:	220 If you outcome of pro	anna.					
death cer a attendir	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
ched the gent of t	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	ordeath 5	Other (specify)				-
hat t	무	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause given in Part I	I.	23e. Did tobacc	o use contribute to	the cause of death?
Hecords, he law requires t a has been signe tge 2 should be o	1 by	•	•	•	,gg			2 □ No 3 □ P	
requirements	ete			-				-	
0 8 20	ompleted						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
_ ⊢ ± 6	O						1□ Yes 2√2	No 1 ☐ Yes	3000
SION OT VITAL INTENDED BY SECTION TO THE SEATH.  Tor: After this certificate the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Check only one)		
Phys this	15	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	28b. Time of	t 3 DOA Cullet. 4 Nu		5 Residence		cify)
ding l	0	Natural 5 ☐ Pending	(Month, Day Year	njury	Work? M 1 ☐ Yes 2 ☐		d. Describe how in	jury occurred	
Attending r death. ector: After by the fune	cat	(2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be on Black of Laives A	t home farm etc		-	f Location (Street	and Number or P.	ural Route Number,
UIVISION  or Attending after death. Director: Afte	Certification;	4  Homicide determine	28e. Place of Injury - A building, etc. (Spe	ecify)	eet, factory, office	201	City or Town, St.	ate)	arai noute Number,
DIVISIO Pe Hospital or Attendi n 24 hours after death. The Funeral Director: A		29a. Certifier Certifying P	Physician: To the best of my	knowledge death	assurred at the time date as	nd place, and	d due to the source	(a) and manner of	a stated
Hos 24 ho Fun stely	edical	(Check only 2 Medical Exa	aminer: On the basis of exam and manner stated.	ination and/or inv	restigation, in my opinion, dea	ath occurred	at the time, date a	ind place, and due	to the cause(s)
DIVIS  To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Med	29b. Signature and title of certified	18		29c. License number		29d. [	Date signed (Mont	h, Day, Year)
ا ا ا		hurth	MD		047920	4		30.20	
		20 Name and address of	o completed source of death /	tom 22a\ /T	Print)		1	70.20	-1
		30. Name and address of person who North Turn Turn 31. Date filed (Month, Day, New York)	FNOY 300	A() (1)	RA ST C	AMB	RIDGE	MA	2/6/2
	tate	31. Date filed (Month, Day, Year)	() 1 2 Pegistra Si	gnature	1		- 5 - 7 -	/	10/)
	strar	MAY	4004	we St	and .				

State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** I1a Lee Barr April 30, 2004 11:10AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bradford Oaks Nursing Home Prince George's Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 90 443-10-1202 Director March 18,1914 OK Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show try or other training the inclining and try or other training the inclining at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 Yes 2 No Director Temple Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5603 Holton Lane 20748 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2V No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White by 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Dickson Allene L. Humphrey ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wyneth J. Swett (Daughter) 5603 Holton Lane Temple Hills, MD 20748 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 1,2004 permit. Page Department of Important: If any injury or once. Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Lie 6633 Old Alexandria Ferry Rd Clinton, MD20735 7001 w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** AKKNISCLERATE heart Disease 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been siç r, page 2 should b 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tol DO0 35206 1. Jamesh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Livingston Road Fort WASHington TANNER MM 11701 31. Date filed (Month, Day, Year) MAY 0 32. Resstrar's Signature

Registrar

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2004

	_		1 - For State Registrer	State of I	Maryland / Depa	artment of Health an rtificate of Death	d Mental Hyg	•	L5660
ı	Physici		1. Decedent's Name <i>(First, Middle,</i> Robert	Louis	Cham	bers	2. Date of Dear Month April	28, 2004	3. Time of Death 9:15AM
	√Medid Examin		4a. Facility Name (If not institution,	give street and number		4b. City, Town, or Location of D		4c. County of Death	9.IJAIN
			7301 Webster 1			Fort Washin	_		George's
	Funeral Director		5. Social Security Number 220 50 9311	3. Sex 7. 1 ☑ 1 2 □ F	Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Oct 27,	Year) 9. Birthy Court 1945 Wash	place (State or Foreign htry) ington DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	e Mary	ctor	Maryland Prince	George's	Fort Was				1 ☐ Yes 2 ₩o
	with th	Funeral Director	10e. Street and Number 7301 Webster	Tono		10f. Zip Code	1	Og. Citizen of What Cour	•
	ns 23	eral	11. Marital Status	12. Was Decede	nt Ever in U.S. 13. V	20744 Was Decedent of Hispanic Origin	/ (Specify Yes or No-	United Sta	
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or Items 23e or 28e-1 show te Medical Everal or mast be redified at	by	XX Never Married 2 Married 3 Widowed 4 Divorced	Armed Force	s? □ <sup>No</sup> 1975-	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pi l □ Yes 2∰No Specify:	uerto Rican, etc.)	Black, White,	
5-0	"natu	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of	working	16b. Kind of Business/In	dustry
72	l withir iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4d	//re. /	DO NOT use retired)		The Washing Paper	ton City
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Modical Ever it and the recilified at once.	To Be C	17. Father's Name (First, Middle, La Roy Chamber	•		18. Mother's	Name (First, Middle, M	Maiden Sumame)	
Man	12 sho		19a. Informant's Name/Relationship			g Address (Street and Number or	Rural Route Number,	City or Town, State, Zip	
	Healtl		Roy Chambers (F	ather)		Webster Lane, sition (Name of hatory or other place)  May	_	ngton, MD 25 20c. Location - City or To	
Ē	Pages nent of int: if i		1-1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te Maryland	natory or other place) May Veterans Cemet	0, 2004	Cheltenham,	
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Lice			Name and Address of Facility  lexandria Ferry	Lee Funera	I Home, Inc	6633 014
	Pnysician	8 1/4	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that causely one cause on each	sed the death. Do no ente	er the mode of dying, such as card	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	b. C6	as a compequence of):	Heart	alre		
	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequence of):	failure			
8760,	icate be executed physician and s the burial-transit	Ical		d	La consequence (ii).	~			
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions	s contributing to death	but not resulting in the un	derlying cause given in Part I.		acco use contribute to th	e cause of death? ably 4 \textsquare\textsquare\textsquare
Records,	Physicien: The law re r this certificate has be ral director, page 2 sho	Completed					24a. Was an autopsy perform	prior to con	osy findings available inpletion of cause of 2 No
VIE V	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Other	Death (Check only one		
Division of Vital	ng Phy fter this ineral o	ıtlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of In	jury 28b. Time of	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe hov	nce 6 Other (Specify v injury occurred	)
Divis	in the	Certification:	3 Suicide 6 Could not determine	d 286. Place of I	njury - At home, farm, stre etc. <i>(Specify)</i>	et, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	To tha Hospital within 24 hours a To the Funaral C	Medical	29a. Certifier 1 Certifying 1 (Check only 2 Madical Ex	and manner	stated.	occurred at the time, date and pla estigation, in my opinion, death oc	curred at the time, dat	e and place, and due to	the cause(s)
	To t To t	×	29b. Signature and title of certifier	~ /	M	29c. License number D4792 Print) Benny	7	d. Date signed (Month, I	Day, Year)
1	B321		30. Name and address of person wh	o completed cause of Alakalt	death (Item 23a) (Type, F	7 Benning A	Rel NE #	6304 WA.	SHDC 2002
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 5	2004 32. Re	trar's Signature	books			

Physic	ian	1 - State Registrar AMPND ITEM #1  1. Decedent's Name (First, Middle, Las Sarah E. Cornish	st)	/17/04 <sup>C</sup> JA	rtificate of	Death	2. Date of Dea Month Feb	neg. No. 200 th Day 2004	3. Time of Death
/Med Exami		4a. Facility Neme (If not institution, give 515 Plover Road	street and number)		Salisb	-	ath	4c. County of De	eath nico
Funeral Director		Usual Residence of Decedent	□M 2 <b>X</b> F 78	rs. last birthday) Yrs.	If Under 1 Yea Months Days			9. E 1926	Birthplace (State or Foreig Country) MD
ne Marylan 8e-f show	ector	MD Wicomico		Salisbu	ry				10d. Inside City Limit:
ith with ti 23a or 2	Funeral Director	10e. Street and Number 515 Plover Road			10f. Zip Code 2180	1		10g. Citizen of What U.S.	Country?
filed within 72 hours after death with the Maryland I Hygiene. other than "nature!, or frems 23s or 28s-f show ont, tra Medical Eval.d natural tectorithed at	by	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		Specify Yes or No- irto Rican, etc.)		merican Indian, hite, etc. Black
within 72 ho ene. then "natur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occi kind of work don DO NOT use retir Steril	e during most of w ed)	orking	16b. Kind of Busines	
0 to 0	To Be Co	11 17. Father's Name (First, Middle, Last) Dewey Cornish, Si			SCELII		ame (First, Middle, Elzey		oital
2 E 20 E		19a. Informant's Name/Relationship ( Bonnie Alamo/daug	**		-		Sural Route Number	r, City or Town, State	a, Zip Code)
Pages 1 and inent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☑ Other (Specify	Removal from State	b. Place of Dispo cemetery, cre-	osition (Name of matory or other pl	ace)	Date	20c. Location - City Salisbury	
permit. Pages Department of I Important: If it any injury or o		21. Signature of Funer ty Sayvice Licen	500	2:	2. Name and Add	ess of Facility			,,,,
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. METASTA  Due to (or as a cons	RATIOI sequence of):	V		CANCE		Approximate Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
requires that the death certifica een signed by the attending ph hould be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgaffs? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	∃Ectopic pregnan ∃Other (specify)	су		23d. Date of d Month	delivery Day Year
w requires that been signed b should be deta	b	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause g	iven in Part I.			to the cause of death? Probably 4 Dunknow
The law ate has b page 2 s	Completed	HYPER CHOLEST	ERDLEMIA	1			24a. Was a autops perform	sy prior to med? death	autopsy findings available o completion of cause of ?
ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatier	nt 3 DOA	ther	eath (Check only on Home 5 V eside	ence 6 □Other (SA	pecify)
ne Hospital or Attending Physicien: n 24 hours after death. ne Funeral Director: After this certificately filled in by the funeral director,	Certification: T	27. Manny of Death  1		t home, farm, st	M 1[	ork? ]Yes 2 ☐No			Rural Route Number,
To the Hospital or Attenwithin 24 hours after deat Within 24 hours after deat To the Funeral Director completely filled in by the	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best of my lininer: On the basis of examiner stated.	knowledge, deat lination and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	w.T	M	29c. Licer	-00 605/	15	9d. Date signed (Mo.)	nth, Dey, Year)
		30. Name and address of person who	completed cause of death (I	Item 23a) (Type,	Print)	<del>-</del>	<u></u>	1	

		State Registrar	State of Maryla		artment rtificate				Hygier Reg. N	~ U U		156	
Physicia /Medic Examine	al .	Nerna Elizak     Verna Elizak     Aa. Facility Name (If not institution, give str.)     Church Str.	reet and number)		4b. City, Lus		Location o	Mon May	th D	004 004 4c. County of D Calv	eath	Time of De.	M M
Funeral Director		5. Social Security Number 217 32 4388 1 Usual Residence of Decedent	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. June	of Birth	9.1 9.1 M	Birthplace Country) Iary	(State or Fo	oreign
Maryland ••f show	tor	10a. State 10b. County Maryland Calvert		City, Town or Lo								nside City L I ∐ Yes 2	_
h with the	Funeral Director	10e. Street and Number 1031 Church Stre	et		10f. Zip	Code 657			-	Citizen of What			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene. Impertant if item 27 is marked other then "neturel", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Examinar must be notified at once.	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ∐Yes 2 ☑No If Yes, Give Year or Dates:	-	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Specify Yes , Puerto Rican, e	or No-	14. Race - A Black, W Specifich i	hite, etc.	ndian,	
within 72 hou ane. then "neture to Medical E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Ster	k done d	urina most	of working		Kind of Busine		•	
ould be filed wi	To Be Co	17. Father's Name (First, Middle, Last) Edward Thomas	4				18. Mothe	ds Name (First, M Tie Tho	Middle, Maide OMas	en Sumame)			
alth and Malth and Malth and Market 127 is mar	-	19a. Informant's Name/Relationship (Type James Ewing Jr. S						r or Rural Route La. Baton			в, <i>Zip C</i> oa	le)	
Definition of the Department of the Department of the mportent: If item any injury or other of the Default of t		20a. Method of Disposition 1	moval from State	Place of Dispo cemetery, cred ivet (	matory or of Cemet	<sub>her place</sub> ery	May	Date 7 3 2004	Lu	Location - City sby Ma	ryla		
permit. Departi		21. Signature of Ferroral Service Licensee	ch	4 4	105 B	room	es Ts	Rausch Sland Rd	. Port	ral Ho Republ	Lic M		
Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the de cause on each line.  Due to (or as a conse	ncer	ter the mode	of dying	, such as	cardiac or respira	tory arrest,		App Inte Ons	proximate erval Betwee set and Dea	n th
eath certificate be executed attending physician and for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or k, Jury that initiated events resulting in death) Last	Due to (or as a conse										
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	by P	Part II. Other significant conditions cont	ributing to death but not re		, -	luse give	n in Part I.	23e	Did tobacco	o use contribute	to the ca Probably		
The la ate has page 2	Completed								Was an autopsy performed?	prior death	to complet	indings avai tion of cause No	ilable e of
ng Phys	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Ho  27. Manner of Death  1 Natural 5 Pending investigation	spital: 1 ☐ Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		A Othe Bc. Injury Work	r: 4 □ Nui		Residence	6  ☐Other (S jury occurred	pecify)		
To the Hospitel or Attending within 24 hours after death To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory	, office		28f. Loca City	tion (Street a or Town, Sta	and Number or ate)	Rural Ros	ute Number,	
the Hospit in 24 hour the Funer ipletely fills	edical	(Check only 2 Medical Examination)	cian: To the best of my ki er: On the basis of examinand manner stated.	nation and/or in	vestigation,	in my op	inion, deat	th occurred at the	time, date a	nd place, and c	due to the	cause(s)	
To I To I	N	29b. Signature and title of certifier  Mulder - March	n)		290.	License	number	,	29d. D	Date signed (Mo $^2$ 4 3, 2	onth, Day,	Year)	
12		30. Name and address of person who con Gwyneth Blattau,	apleted cause of death (lite	em 23a) (Type, MHal K	Print)	ute	310	Prince I	Freder	ick, 14	102	0678	/
Sta Registr	te ar	MAY 0 4	2004	er St.	Spa	ela s							

			For Stata Registrar	State of	Maryla		artment		ealth and M Death		iene <sub>ag. No.</sub> 2 (	04	15663
			Decedent's Name (First, Middle)	, Last)						2. Date of Deat	h		3. Time of Death
	Physici /Medic		WILLIAM	FRANKLI	N EIB	NER				Month 5	Day 3	O4	11145AM
	Examin		4a. Facility Name (If not institution, Atlantic Gen	-				wn, or terlin	Location of Death		4c. County Wot	of Death	er
	Funeral Director					. last birthday, Yrs.	If Under 1 Months [	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3/17/1	Year)	9. Birthp Cour	place (State or Foreign
-			Usual Residence of Decedent		10.0					3/1//1	320		
	n the Maryland r 28a-f show	2	MD Word	ester		ity, Town or L Ocean						1	10d. Inside City Limits 1 ☐ Yes 2 XNo
	28a-f	Director	10e. Street and Number				10f. Zip C	ode		1	0g. Citizen of	What Cour	
	23a or		10028 Silver	Point Lar	ne			2184	2		USA		,.
	after death with or Items 23a or mitter must be	Funerai	11. Marital Status	12. Was Deced	dent Ever in l	J.S. 13.			panic Origin? (Spe , Mexican, Puerto I	cify Yes or No-	14. Rac		can Indian,
الا 86	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Items 23a or 28a-f show ont, the Modical Examiner must be maiffed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		2 □ No 9		1 ☐ Yes 2	_	Specify:	nican, etc.)	Specif	ck, White, y: <b>Wh</b>	ite
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7 2	be filed with tal Hygiene. d other that event, the N		12 17. Father's Name (First, Middle, L	_ast)		<u> </u>	ireman		18. Mother's Name	(First, Middle, M			city
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ary Sar	d 2 shooth and hold is maintained trauma		19a. Informant's Name/Relationsh			1			nd Number or Rura				Code)
A COM	s 1 and 2 f Health item 27 i	13	Bessie Harde	sty	20h	1183 Place of Dispo			iccaneer				1811
ELBA S.M3 artimor	of of the second		20a. Method of Disposition  1    Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		State	cemetery, cre dar Hi	matory or other	eter	y 5/6/	04	Baltime	ore,	MD
हैं श्री Balt	permit. Pag Department Important: any i jury o		21. Signature of Funeral Service L	icensee	a LAG F	2	2. Name and a	Address Ilian	of Facility he In St. Ber	Burbage	Funer 2181	al Ho	ome
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that on	used the dea								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		chios		CAN						Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a conse	quence of):							
		er	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that is likely as or injury	b. Due to (c	or as a conse	quence of):							
	cuted nd ransit	Examiner	man minated events	С,									
90,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (d	or as a conse	quence of);							
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tal	icien: Th certificate rector, pag	Be Co	25. Was case referred to medical						26. Place of Death			Yes	2 □ No
<u> </u>	Physicien: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 In	patient 2	] ER/Outpatier	nt 3 DOA	Other				er (Specify	1)
o u	tending Ph leath. tor: Afler th the funeral	lon:	27. Manner of Death 1 ☐Natural 5 ☐ Pending		f Injury n, <i>Day Year)</i>	28b. Time o Injury	f 28c	. Injury a Work?	at 2 es 2 ⊡No	8d. Describe ho	w injury occurr	ed	
isio	of or Attendi: after death. I Director: A d in by the fu	ficat	2 Accident investig: 3 Suicide 6 Could n	at he	of Injury - At h	nome, farm, sti				8f. Location (Str	eet and Numb	er or Aurai	l Route Number,
Div	tel or / s after al Dire ed in b	Certification:	4  Homicide determine	buildin	g, etc. (Speci	ity)				City or Town	State)		
	To the Hospitel or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	Physicien: To the texaminer: On the base and manner	sis of examin	owledge, deat ation and/or in	h occurred at vestigation, in	the time my opir	, date and place, a nion, death occurre	nd due to the ca d at the time, da	use(s) and ma te and place, a	nner as stand due to	ated. the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	11/11	7		29c. L	icense r	number	29	d. Date signed	(Month, L	Day, Year)
			11-0	,-,_	- 6	20		442	83		5/3/2	204	
1-	H DN.		30. Name and address of person v		of death (Ite	m 23a) (Type, 4 <i>LTHWA</i>	Print) 4 DA 1	BERL	LIN MO	01811		,	
9	Sta		31. Date filed (Month, Day, Year)		igistrar's Sign		1			~1011			
	Registr	ar	MAY 0 4	2004	Mes .	15. Ps	care			1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Parran Alexander Ford Day Physician 26 2004 April3:50p /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LaPlata Civista Medical Center Charles If Under 1 Year | If Under 24 Hrs.
Wonths | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Aug. 8, 1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 219-12-0215 6. Sex **Funeral** 1**◯X**M 2□ F Months Days 81 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b County 10c. City. Town or Location or 28a-f ehov 1 ☐ Yes 2 No Calvert Dunkirk Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20754 4280 Ferry Landing Road USA 23a Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 ō 1□Yes X□No Specify ρ 3 ☐ Widowed 4 ☐ Divorced "natural" or than "nature the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatic event. In a Monce. Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ford Wilson Alexander Juanita 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6707 Wilburn Drive Capitol Heights, MD Calvert Ford/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Cooper's UMC Cem. 5/1/2004 Dunkirk, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Sewell 1451 Dares Beach Rd. Funeral liome 2 Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2/05/5 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, certificate has Be 2 After this funeral Certification: death. within 24 hours after death To the Funerel Director: filled in by ical

examiner'

27. Manner of Death

10 Natural

2 Accident

1 ☐ Yes 2 ☑ No

5 Pending

investigation

6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Chack only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

MO

2 ER/Outpatient

28b. Time of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 thpatient

28a. Date of Injury (Month, Day Year)

10 Patricks Dr., Ste. 404, Waldorf, MD 20603 MD, St. Nalin Mathur, 31. Date filed (Month, Day,

3□ DOA

28c. Injury at Work?

D-52289

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2001

State Registrar

unpend item#23a,27,28a-f,PER ME,C832,6/8/04eg
Please Type or Print in Black Indelible Ind.

Physici		Decedent's Name (First, Middle								2. Date of De		004		of Death
/Media		John Patrick	Ford, Jr.							Month May	07	2004	6:00	Α
Examir		4a. Facility Neme (If not institution		ber)		4b. City,	Town, or	Location o	f Death		4c. Cou	nty of Deat		
		1515 Haviland					der.		0.4.11			Frede		
Funeral Director		5. <b>214</b>	6. Sex 7	7. Age (In yrs. 37	Yrs.	If Under Months		If Under 2 Hours	Min. A	8. Date of Birl (Month, Da ugust	th 9, 1966	9. Birth	nplace (Statuntry) CONSIT	e or Fore 1
M H		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside	
Sa-f sh	Director	Maryland Fred	erick	Fr	ederic	k 							1 <b>/2</b> Y	es 2 🗆 I
ms 23a or 28a-f show	al Dire	10e. Street and Number 1515 Haviland P	1ace			10f. Zip		21702	2		10g. Citizen (	of What Co A •	untry?	
or ite	by Funeral	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give	es? No	1	Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	- 14. F	Race - Amer	e, etc.	
	ted b	15. Decedent (Specify only highes	Year or Dat	les:	16a. Deced		(1)	tion	- 6 d-i-		16b. Kind of	WI	nite ndustry	
63	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)	Depar				or workin	g	Gra	ocery		
Hygiene. other than ent, the M	Be Co	17. Father's Name (First, Middle, I			Бераг	<u> </u>			r's Name	(First, Middle,				
nd Mental marked o	ToB	John Patrick							ol A					
h ar		19a. Informant's Name/Relationsh Tammy Ford - Wi			19b. Mailin	g Address Havil	(Street a and	<sup>nd Number</sup> P1ace	ror Aural	Route Numbe edericl	er, City or Tow k, Mary	m, State, Z. yland	ip Code) 2170	12
e E		20a. Method of Disposition  1    Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		0	Place of Dispo- cemetery, crem 01ivet	natory or ot	her place	5	Da /12/2		20c. Locatio	•		and
Department of the important: If its any injury or or once.		21. Signature of Funeral Service L		Qui &		. Name and			51	auffer lke, Fr				d
Medical xaminer	ılner	Sequentially list conditions, I any leading to initiallate cause. Enter Underlying Cause (Disease or injury	b. ————	r as a consequence of as a nonsequence										
nysician and he burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	r as a consequ	uence of):									
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State of Maryland / Department of Health and Mental Hygiene ~2~0~0~  $\downarrow_{\downarrow}$ 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Edward Frederick Mav 2004 1:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City Howard 10206 Green Clover Court If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3/13/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 81 189 12 0241 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or itema 23a or 28a-f show the Medical Examiner must be rotified at 1 ☐ Yes 2X No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10206 Green Clover Court 21042 United States Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Armed Forces:

Types 2 No
If Yes, Give
Year or Dates: 1943-46 1 Never Married 212 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer <u>Westinghouse</u> other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Peges 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic even Edward G. Frederick Hilda B. Haas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $21042\,$ Eurla H. Frederick/Wife 10206 Green Clover Ct Ellicott City MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☑Removal from State permit. Pege Department of Important: If any injury or once. Lakewood Mem. Gard.5-7-2004 Cheswick, PA \* 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01044 22. Name and Address of FacilityHarry H. Witzke's Family FH 4112 Old Columbia Pike Ellicott City MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 Schemic ears Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and ned for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetaf death Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by lar Acciden 3 ☐ Probably 4 ☐ Unknown 1 TYes 25 No peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 2 **X**No 1 ☐ Yes ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA ٩ this filled in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: or Attending Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Hospital 29a. Certifier 1[XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) May 3, 2004 BOTI completed cause of death (Item 23a) (Type, Print) ded 31. Date filed (Month, Day, Year)

**ORIGINAL** 

Registrar

State

			1 - For State Registrar	te of Maryland / De	epartment Certificate				iene <sub>eg. No.</sub> 20	104	156	567
	Physicia		1. Decedent's Name (First, Middle, Last) Louise	V .	Gross			2. Date of Deat April	_	2 <sup>Yea</sup>	3. Time of 0 4:20	
	/Medic Examin		4a. Facility Name (If not institution, give street a 3800 Cassell Blvd	nd number) •	Princ	own, or Location	deric	k	4c. County Ca	1vert		
	Funeral Director		5. Social Security Number 219-48-8925  G. Sex  1 M 2  Usual Residence of Decedent	7. Age (In yrs. last birtho	Months	Year If Und Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month Day, ay 22,	<sup>Υθ<b>η</b>(1)</sup> 945	9. Birthpla Mary	ace (State or 71and	· Foreign
	ith the Maryland or 28a-f show	ector	10a. State 10b. County  Maryland Calver  10e. Street and Number	t 10c. City, Town o	ince F		.ck		On Citizen of		od. Inside City 1 ☐ Yes	
	th with t	al Dir	3800 Cassell Blv		10f. Zip C	0678			0g. Citizen of US		·yr	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent. The Midfell Examinational Dance.	d by Funeral Director		Yes 211 No es, Give ir or Dates:	13. Was Decede If Yes, specif 1 Yes 2	XNo Speci	fy:			ce - America ck, White, e y: Bla	tc.	
21215-0036	within 72 h ene. than "natu re W. dical	Completed	15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12)  1 1	ege (1-4or 5+)	ecedent's Usual Give kind of work fe. DO NOT use Custo		ost of workin	ng	16b. Kind of B		·	
Maryland 2	should be filed with nd Mental Hygiene, i marked other thai umatic avent, Tre 1	To Be Co	17. Father's Name (First, Middle, Last) Benjamin	Pervey		18. Mot	ther's Name eatri	(First, Middle, I	Maiden Sumar	Gros	s	
Mary	nd 2 sho Ith and It 27 Is ma		19a. Informant's Name/Relationship (Type, Prin Lawanda Gross/Daug	1 .	Mailing Address (				-			0678
Baltimore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr.		20a. Method of Disposition  14 Burial 2 Cremation 3 Remova  4 Donation 5 Other (Specify)	from State 20b. Place of D cemetery,	isposition (Name crematory or oth nd Ceme	of er place)		ate	20c. Location Huntil	City or Tov	vn, State	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  ### ### ### #######################	ell	22. Name and 1451 D	Address of Fac ares I	Beach	well F Rd. P	unera: rince	l Hom Fred	e .,MD2	2067
	Pnysician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	on each line.	al lo	of dying, such a	as cardiac or	respiratory arre	est,		Approximate Interval Betw Onset and D	reen reath
8760,	Examiner	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of)  COVICAT  US to (or as a sonsequence of)  ue to (or as a consequence of)	Cdr	cer						
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ysiclan/Med	in the past 12 months?	es, outcome of pregnancy Live birth 2 ☐ Fetal death Pregnant at time of death Unknown	3 □Ectopic prec					te of deliver		ear
<u>α</u>	w requires that to be been signed by should be detail	by	Pad II. Other significant conditions contribution  Venous	g to death but not resulting in the		ise given in Pai	rt I.		oacco use conf es 2 □ No	tribute to the		ath?
I Records,	i <b>iclan:</b> The law rec certificate has bee rector, page 2 shor	Completed	Vainary trac	t mecho	<u>-0</u>			24a. Was a autops perform 1 Yes 2	y neg2	Were autopoption to comdeath?	sy findings a pletion of car	vailable use of
Vital	Physiclan: this certifical	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital	1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA	Other	ice of Death Nursing Hom	(Check only on	e) ence 6 □Oth	ner (Specify)		
ion of	Jing After fune		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b. Tim Inju		o. Injury at Work? 1 ☐ Yes 2	2	8d. Describe ho		. , ,,		
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm building, etc. (Specify)	, street, factory,	office	2	8f. Location (St. City or Town	reet and Numb n, State)	er or Rural	Route Numb	er,
	To the Hospital within 24 hours of To the Funeral completely filled	edical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, of the basis of examination and/of manner stated.	death occurred at or investigation, in	the time, date n my opinion, d	and place, a eath occurre	nd due to the ca d at the time, da	ause(s) and ma ate and place,	anner as sta and due to t	ted. he cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	1	29c.	License numbe	r 00	29	9d. Date signe	d (Month, D	ay, Year)	
			30. Name and address of person who complete	Cause of death (Item 23a) (Ty	/pe, Print)	0 59	409		110	Hospi	ital R	<u> </u>
	4		ISSA TUSUF	Shah Assoc	, Calvert	medic	al OF	Fice B	dg. Prin	ce Fre	d MD	30618 a.
	Sta Registi		31. Date filed (Month, Day, Year) APR 3 0 20	32. Registra Signature	4 Spen	L.			~			

			1 - For State Registrar	State of Man		artment of Heartificate of De		ntal Hygie	201	04 15668
	Physici	20	1. Decedent's Name (First, Middle, La	st)	•		2	P. Date of Death Month		3. Time of Death
	/Medic		Christine		Gag	liardi		May .	3 20	
	Examin	er	4a. Facility Name (If not institution, giv	2 1 1 11	.//	4b. City, Town, or Lo		•	4c. County of	
			5, Social Security Number 6.5	laryland Ho	ospital In ys. last birthday)	Daltma If Under 1 Year If		I. Date of Birth	No.	Birthplace (State or Foreign Country)
	Funeral Director	j		CH OME	9 Yrs.	Months Days H	lours Min.	(Month, Day, Yo		Maryland
9	P .		Usual Residence of Decedent		0- 0'- T					10d. Inside City Limits
	show	5	10a. State 10b. County		Oc. City, Town or Lo					1 ☐ Yes 2X No
	28e-1	ect	MD Howard  10e. Street and Number		Colu	nbia 101. Zip Code		100	. Citizen of Wha	at Country?
	with the	10	5101 West Penf	ield Road		21045		"	_	States
	death with the Maryland one 23s or 28e-f show	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hispa	nic Origin? (Speci	fy Yes or No-	14. Race -	American Indian,
9	or Ite	Fui	Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuban, N 1 ☐ Yes 2 🔯 No S	nexican, Puello Ni Specify:	can, etc.)	Specify:	White, etc.
21215-0036	4 within 72 hours after death with the Marylan jiene. r than "natural", or Iteme 23a or 28e-1 show the Madical Extrainer: wat be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						White
15	n 72 h	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	7	b. Kind of Busin	ess/Industry
12	within iene. then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ıdent		1	Educat	ion
	Hyg Hyg ent,	a)	17. Father's Name (First, Middle, Last	)			. Mother's Name (			
lar	Q 22 D 9	To B	N. Joseph Gagl	iardi		D	iane Dz	idusko		
Maryland	s 1 and 2 should be f Health and Mental item 27 1s marked other traumatic ev		19a. Informant's Name/Relationship	**		ng Address (Street and			-	
	2号 Z T T T T T T T T T T T T T T T T T T	1 %	Dr. N. Joseph	Gagilardi	/ 51U.	the second second	nileid			a, MD 21045 y or Town, State
jor			20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □		cemetery, cre	matory or other place)				
Baltimore,	그 문문을	. 0	* 4 Donation 5 Other (Special Service Lice							ville, MD s Family FH
Ba	Depa Impo any is		I Them Coll	- Wir	~ /					tt City, MD
+ 1			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the	e death. Do not en	ter the mode of dying, s	uch as cardiac or i	respiratory arrest		Approximate Interval Between Onset and Death
8760,	death certificate be executed  e attending physicien and deattending physicien and at the burial-Iransit	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):	Angios	arcoma			
687	icate i	edical		_ d						
O. Box	che che	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 W No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2   4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	
Vital Records, P	₽ B B	þ	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause given in	n Part I.			ite to the cause of death?  Probably 4 Unknown
200	law requires as been sign 2 should be	Completed						24a. Was an	24b. Wei	re autopsy findings available
Re	0 2 0	mo					<del></del>	autopsy performed	d?/ dea	r to completion of cause of th? Yes 2□ No
ital	ician: Th certificate rector, pag	0	25. Was case referred to medical			26	S. Place of Death (		TNO 12	163 20110
_ <	d is	To B	examiner? 1 ☐ Yes 2 No	Hospital:   ↑ Inpatient	2 ER/Outpatie	nt 3 DOA Other:	4 ☐ Nursing Home	9 5 ☐ Residenc	e 6 Other (	(Specify)
n of			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Work?		d. Describe how	injury occurred	
sio	eatl or:	catl	2 Accident investigation 3 Suicide 6 Could not I				2 No	4 Landing (Chan		- C ( C
Division	in the s	Certification;	4 Homicide determined		r - At home, farm, st (Specify)	reet, factory, office	28	City or Town, S		or Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical		hysician: To the best of eminer: On the basis of eminer state	xamination and/or in					
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License nu				Month, Day, Year)
			) The	) mo		P137	72	M	lay 3	2004 and 21201
0),	12		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type,	Print)	0.14		1	
7	٠ -		Ben Bridges	22 Sout	h Green	e Street,	Baltin	nore,	Moryla	ind 21201
	Sta	ate	31. Date filed (Month, Day, War)	. Hegistrar	s oignature	1 AP 1			,	

			For State	State of Ma	ryland	/ Depa		ealth and I	Mental Hyg		101.	15000
_			Registrar			Cei	rtificate of L	Jeatn	2. Date of Dea	Reg. No. 2 (	104	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)	Ivan M.	C 2 201	~ <b>~</b> ~			Month	Day	Year	7:45 au
	/Medic	du .	4a. Fecility Name (If not institution, give :		Garı	llan	4b. City, Town, or	Location of Death	April	25 2 4c. County	2004 of Deeth	
	Examin		27329 Iron Gate				,	lsburg			colir	ıe.
3). <sup>2</sup>	Funeral	and a	5. Social Security Number 6. Sex	7. Age	(In yrs. las	st birthday)	If Under 1 Year Months Days		8. Date of Birt			lace (Stete or Foreign try)
	Director		213 03 9014 1 <sup>12</sup>	M 2□F	93	Yrs.	Months Days	Hours Mill.	3/4/1			sylvania
_	D .		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	ecation				1	0d. Inside City Limits
	shov	'n										1 ☐ Yes 2√∑ No
	the N	Director	MD Carolir  10e. Street and Number	ie	F'6	edera	alsburg			10g. Citizen of	What Coun	trv?
	with with	I DI	27329 Iron Gate	Road			21632			Unite		
	ms 2	Funerai		12. Was Decedent E	ver in U.S.	13.	Was Decedent of Hill If Yes, specify Cubar		pecify Yes or No-		e - Americ	an Indian,
٥	or ite		1 Never Married 2 Married	Armed Forces?  1  Yes 2 XNo If Yes, Give	0		i Yes, specity Cubai 1 □ Yes 2 127 No	Specify:	o rican, etc.)	Specif	ck, White,	яс.
9500-61212	swithin 72 hours after death with the Maryland piece. Than "naturel", or items 23s or 28s-f show the Medical Exactinet must be rediffed at	d by	3 ☐ Widowed 4 🔀 Divorced	Year or Dates:							W	hite
ភ្ន	nett Allca	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired,	ation during most of wor	rking	16b. Kind of B	usiness/Inc	ustry
7	within 72 ene. than "nei to Medic	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	+)	Buil		/		Colf	Emm 1	0110 4
	Hyg Hyg Sthe		17. Father's Name (First, Middle, Last)			Dull	-uei	18. Mother's Nan	ne (First, Middle,	Self Maiden Suman		oyea
a	ld be ental ked c	To Be	Henry H. Garman	ı				Susanna	a Musse	r		
Maryland	shou and N s mar		19a. Informant's Name/Relationship (Ty				ng Address (Street a					
	and 2		Earl Garman/Son						-	e Rd W	estm	inster MD
ore O	ges 1 an it of Heal if item 2 or other		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F	iamoval from State	20b. Pla	ce of Dispo netery, crei	sition (Name of matory or other place	a)	Date	20c. Location -	City or To	wn, State
Ě	nit. Pages artment of ortant: If it injury or o		`4 □Donation 5 □ Other (Specify)				idge Ce					
Baftimore,	permit Depart Import any in		21. Signature of Funeral Service Licens	· Wille	L044							amily FH City, MD
	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the cause of	the death.	Do not ent	er the mode of dying	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between
	Pnysician	(0 )	Immediate Cause (Final disease or condition	Cic	100	VEN CIV	. Drte	4 00	Hose			Onset and Death
	/Medical		resulting in death)	Due to (or as a	conseque	nce of):	-	1				
	Examiner	L	Sequentially list conditions,	Due to (or as a							_	
	bed isit	nine	Sequentially list conditions, if any, leading to immediate cause. End no erlyin Cause (Disease or injury	D00 10 (01 25 a	Conseque	1100 01).						
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):						
760		call		J								
89		-	IC CCMM C									
Вох	th cei tendii r use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o			Ectopic pregnancy			1	te of delive onth	ry Day Year
0	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	1 Yes 2 No	4□Pregnant at t 9□Unknown	time of dea	ith 5	Other (specify)			1010	A161	,
٦.	ires that the de signed by the a I be detached I	Ph	Part II. Other significant conditions con	ntributing to death bu	t not result	ing in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	tribute to th	e cause of death?
Records,	uires sign ld be	d by	Dabetes	mellitus	5 +	use	T		1 🗆 Y	es 2 DNo	3 ☐ Proba	ably 4 □Unknown
Ö	w require been si should b	lete	1000 00	to insur		,			24a. Was	an 24b.	Were autor	osy findings available
Ř	he law e has age 2 :	Completed	- May pe	1/601310	~ 1					rmed?	prior to con death?	npletion of cause of
Vital		e e	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only o		1 🗌 Yes	2 NO
	ysicii is cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatien	nt 2 E	R/Outpatier	nt 3 DOA Othe		lome 51 Resid		er (Specify	)
Division of	Attending Physician: r death. actor: After this certific by the funeral director.	L:uc	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injury (Month, Day	y Year) 2	8b. Time o	f 28c. Injury Work	at (?	28d. Describe h	ow injury occur	red	
<u> </u>	eath. or: Ai	catic	2 Accident investigation					Yes 2 □No				
Ž	or Att fter d jract in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.		ne, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rura	Route Number,
<b></b>	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or			sician: To the best of								
	the H nin 24 the Fi	Medical	one)	ner: On the basis of and manner stat	ted.	a.iworin						•
	Vwith To COUT	2	29b. Signature and title of certifier	Thi	, ,	1 0	29c. License	number		29d. Date signe	a (Month, L	/ey, rear)
,	(0)		alle	1 The	<b>f</b> /	n-PJ.	1/2	1629		7 - 0	117	:7
	dal		MACHININI	MP. bi	D PC	affin	Lane	Dento	on, Mh	0 21	620	
	Sta Registr		31. Date filed (Month, Day Year)	Registra	r's Signatu	re	uff					

			Pie	45e 1	-			epartmen				•			oie.		
		•	For State Registrar		Otato of			Certificate			LITTO TVI		Reg. No	Z U I	) 4	156	70
	Obvojaj		1. Decedent's Name (First, Mide	dle, Last)								2. Date of De Month	ath Da	v	Year	3. Time of D	eath
	Physici /Medio		KNEA			C	HAI	RRINGT	ON_	SR.		April	28,	, 20		12:10	a <sup>M</sup>
	Examin	er	4a. Facility Name (If not instituti					4b. City,	Town, o	r Location of	f Death		4c	. County	of Death		
			Berlin Nursi						rli:	n If Under 2	04 Hrs	0.0		Worc	est	er	
- 0	Funeral		5. Social Security Number 217-26-3717	6. Sex 1 🖼	M 2□F	7. Age (In yrs 7.		Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)		9. Birth Cou	place (State or I	
	Director		Usual Residence of Decedent			1.5	±					9-22	-29			Md	•
	yland		10a. State 10b. Count	у		10c. C	ity, Town o	r Location								10d. Inside City	Limits
	Mar	tor	Md. Wor	cest	ter		ocear	n Pine	S							1 Yes 2	! 🗌 No
	within 72 hours after death with the Maryland ene. then "netural", or Itams 23e or 28e-1 ehow In Medical Examinational De notified at	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Cit	tizen of W	hat Cou	ntry?	
	23a	al	11 Crest Ha	ven	Drive	9			21	811				U.S	. A.		
	r dea	Inel	11. Marital Status	1	12. Was Dece Armed For	dent Ever in U ces?	J.S.	<ol> <li>Was Deced If Yes, spec</li> </ol>	ent of H	lispanic Orig an, Mexican,	in? (Spec	cify Yes or No Rican, etc.)	)-	14. Race		can Indian, etc.	
36	or It	by Fu	1 Never Married 2 Ma	rried	1 ☐ Yes If Yes, Give	2 No		1 ☐ Yes 2		Specify:				Specify:		hite	
STER K. 21215-0036	fours fural	q p	3 Widowed 4 Divorce		Year or Da	ites:	164 D	a a a da a a la la la la la la la la la la la l	10				101 16		VV		
문 <b>15</b>	n 72 "na	Completed	15. Decede (Specify only high	est grade	completed)		loa. Di	ecedent's Usua Give kind of wor fe. DO NOT us	k done e e retirec	during most	of workin	g	160. K	ind of Bus	siness/ir	idustry	
ST.	filed withi Hygiene. Ither ther	E O	Elementary/Secondary (0-12)		College (1-	4or 5+)	}	Fran					Co	nvi	ene	nt Sto	re
CHESTER and 21215	Hygie other	BeC	17. Father's Name (First, Middle	, Last)				r_aı	1411		r's Name	(First, Middle,					
	lid be ked c	To B	Chester K.	Harı	ringto	n				Fra	nces	s Kirk	v				
a',	uges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic event, It a Madical Expriner must be notified at		19a. Informant's Name/Relation	ship (Ty)	oe, Print)		19b. M	lailing Address	(Street					or Town, S	State, Zij	Code)	
O Z	1 and 2 Health a iom 27 is		Marianne Har	ring	gton		11	Crest	: На	aven	Dr.	Ocean	Pi	nes	. M	218	11
GI	of He of He fiten r oth		20a. Method of Disposition 1   Burial 2 □ Cremation	2 □ D.	omouel from C	20b.	Place of D cemetery,	isposition (Nam crematory or of	ne of ther plac	се)	Da	ate	20c. Lo	ocation - (	City or T	own, State	
I E	Peges nent of ant: If it ury or o		`4 □Donation 5 □ Other (		emoval nom s		verg	reen (	Cem.		5-1-	-04	Ве	rli:	n, I	Md.	
HARRINGTON, Baltimore, Mary	permit. Peges 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service	a License	of f			22. Name and	d Addres	ss of Facility	/						
HA B	207 2 2		MINO (	Mu	1									lin	, Mo	d2183	11
			23a. Phot. Enter the disease, shock, or heart failure. Lis	or complication	cations that ca e cause on ea	used the dea	th. Do not	enter the mode	of dyin	g, such as c	cardiac or	respiratory ai	rrest,			Approximate Interval Betwe	en
	Physician	E 119	Immediate Cause (Final disease or condition	a	M	etast	extre	Carci	non	not 0	1 4	102450	le			Onset and De	
	/Medical Examiner		resulting in death)		Due to (d	or as a conse	quence of):										
	- Automici	la.	Sequentially list conditions,	ь	. Due to (s	or as a conse	Tues of \( \)		-						_		
	per tist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	DI 9 10 (C	or as a conse	quence or):										
	xecul and al-trai	xan	that initiated events resulting in death) Last	C.	Due to (c	or as a conse	quence of):								-		
760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	caiE															
687	leath certificate attending phys I for use as the	edic		u.													
Вох 68	nding use	N/M	IF FEMALE: 23b. Was decedent pregnant	20	3c. If yes, outc			· 🗆						23d. Date	of deliv	ery	
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4□Pregna	nth 2 ☐ Fetant at time of		3 ☐ Ectopic pre 5 ☐ Other (spe						Mont	th	Day Yea	ar
0.	that the de ted by the a detached to	Physician/Medi	9 Unknown		9□ Unkno	wn									_		
S,	w requires that s been signed I s should be det	by F	Part II. Other significant condit	ions con	tributing to dea	ath but not re	sulting in th	e underlying ca	luse givi	en in Part I.		23e. Did to	obacco u	se contril	bute to t	ne cause of dea	th?
ord	equir sen si ould											1 🗆 \	/es 2[	□No 3	3   Prot	ably 50nk	inown
e C	e lawr has be ge 2 sh	Completed										24a. Was		24b. W	ere auto	psy findings ava	ariable se of
<u> </u>	The ate h page	Con										perfo	rmed?	de	ath?	2/K1No	
/ita	cian: ertific ector,	Be (	25. Was case referred to medic examiner?						45		of Death	(Check only o	ne)				
Ž	Phyeician: The la r this certificate has iral director, page 2	2	1 ☐ Yes 2 No	H		patient 2				Nurs	sing Hom	e 5 🗆 Resid	dence (	6 Other	(Specif	y)	
u u	ing P	0	27. Manner of Death  Statural 5 Pend		28a. Date of (Month)	f Injury o, <i>Day Year)</i>	28b. Tim Inju		3c. Injun Worl			8d. Describe h	now injur	y occurre	d		
Sio	tend leath tor: / the f	cat	2 Accident inves 3 Suicide 6 Could	tigation not be	OO - Disease	-61-5 445		М		Yes 2□N		04 1 1 10					
Division of Vital Records, P.O.	or At after Direc in by	Certification;	4 Homicide deter	mined	buildin	g, etc. (Speci	iome, rarm	, street, factory,	office		20	City or Tou	vn, State	a Numbei )	r or Hura	l Route Number	ζ,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 Certify	ina Phys	ician: To the l	hast of my kn	owledge d	eath occurred a	it the tim	ne date and	I place ar	ad due to the	causa(s)	and man	200 20 0	tatad	
	24 hos 24 hos 5 Fun etely	Medical	(Check only 2 Medica one)	I Examin	er: On the ba	sis of examina	ation and/o	r investigation,	in my of	pinion, death	occurred	d at the time,	date and	place, ar	nd due to	the cause(s)	
	To the within 2 To the complet	Me	29b. Signature Amelyith of certifi	er	c			29c.	License	e number			29d. Dat	e signed	(Month.	Day, Year)	
			MATHIE	de.	Lin			E	)D	876	9		4/	281	06	1	
C	To		30. Name and address of perso	n who cor	mpleted cause	of death (Ite	m 23a) (Ty	pe, Print)	20	)9.	Ces	as tech		ten 1	tiw	75-111	1
C.	18		NIMOLOS N	1 150	Drady	110,0	w	F	Eu	wick		Fyler	1,	De	_ (	1994	1
- 1	Sta Registr		31. Date filed (Month, Day, Yea	0 201	32.76	gistrar's Sign	ature	Charles					/				

		Please I	State of Maryland /	/ Depart	tment of Haricate of L	ealth and N	lental Hyg	giene 2001	15671
Physic		1. Decedent's Name (First, Middle, Last)  PAUL ROGER I	HLL				2. Date of Dea Month 4	Day Year 30 2004	3. Time of Death  12:35P <sup>M</sup>
/Medi Exami		4a. Facility Name (If not institution, give standar La	reet and number)	4	b. City, Town, or Showell	Location of Death		4c. County of Dea	th
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat 1/19/1	9. Bin (, Year) 928	thplace (State or Foreign puntry)
faryland show	ō	Usual Residence of Decedent  10a. State 10b. County  MD Worceste		own or Local					10d. Inside City Limits 1 ☐ Yes 2 📉 No
death with the Maryland ms 23e or 28e-f show (must be notified at	Director	10e. Street and Number		Showe	10f. Zip Code 2 18	062		10g. Citizen of What Co	ountry?
	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:			spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		te, etc.
지 경고도의	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kır. life. DO	NOT use retired,	luring most of worl )	ang	16b. Kind of Business	,
E Baby	To Be Cor	17. Father's Name (First, Middle, Last)  Rowland Hill	2	Wedic	cal Rese	18. Mother's Nam	e (First, Middle,	Governme Maiden Sumame) enson	ent
re, Maryla s 1 and 2 should f Health and Men itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Stephen Hill	e, Print)					n, City or Town, State,	
	La	20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	amoval from State	e of Dispositi etery, crema	ion (Name of tory or other place open Cr	e) 5/3		20c. Location - City or Frankford	Town, State
Baltimo permit. Page Department of Importent: If any injury or		21. Signature of Funeral Service License		22. N	Name and Addres		e Burba	ge Funeral	Home
Physician		23* Part1. Enter thi disease, or complishock, or heart Filure. List only in Immediate Cause (Final disease or condition resulting in death)	tions that caused the deals. The cause on each line.	o not enter	the mode of dying		or respiratory a	rest,	Approximate Interval Between Onset and Death I-2 year
/Medical Examiner			Due to (or as a consequen						
60, be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen						
68760 ilicate be e g physician as the buria	edicai	Ld							
death cert death cert death cert death cert death cert death cert death	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	eath 3□E	ctopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
dS, P.O. I puires that the de n signed by the a lid be detached is	by	Part II. Other significant conditions con	tributing to death but not resultin	ng in the und	erlying cause give	en in Part I.	23e. Did t	obacco use contribute to	o the cause of death? robably 4 Unknown
Records, P.O The law requires that the ate has been signed by the page 2 should be detached.	Completed						24a. Was autor perfo		utopsy findings available completion of cause of
of Vital Re Physician: The la rthis certificate haver ral director, page 2	Be	25. Was case referred to predical examiner?	ospital:		othe Othe	26. Place of Dea			
Division of Vital to Attending Physician: after death. Director: After this certifica	tion; To	1 Yes 2 No  27. Manner Peath 1 atural 5 Pending 2 Accident investigation		VOutpatient Bb. Time of Injury	28c. Injun Work	4   Nursing H		dence 6 Other (Spenow injury occurred	acriy)
Division or to the Hospital or Attending Phemin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	it, factory, office		28f. Location (. City or Tou	Street and Number or R vn, State)	lural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (		sician: To the best of my knowle ner: On the basis of examination and manner stated.						
To the within 2 To the complet	M	29b. Signature and title of certifier  Kusture it	Suipin N	10	29c. License	o number 20067	95	29d. Date signed (Mon $3-3-0$	th, Day, Year)
T 5+1		30. Name and address of person who co	mpleted cause of death (Item 23	3a) (Type, Pr	int) COA	BTAL F	116 Hu	Ay FEWY	UICIL TSLAMO
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	e do	aste s		DE	19940	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n Registrar #9A, per/physician, 5/4/04, Certificate of Death WCHD 2. Date of Death Month **Physician** 2, М 2004 May 1625 HECK LLOYD /Medical 4a Facility Name (If not institution, give street and number)
10511 Griffin Road
10551 Griffin Road 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Berlin

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Yrs Director 217-26-3669 74 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23s or 28s-1 show any injury or other treumatic event, Ite M. alcal Examinating the notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Directo MD Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10511 Griffin Road 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No ξ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lloyd R. Heck Marion L. Knotts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 10511 Griffin Rd, Berlin, Md., Nancy L. Heck 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 Aeremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) \$alisbury Crematory Salisbury, Md. 21. Signature of Foneral Service Ligensee 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md. TININ N 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) set and Death **Physician** /Medical **Examiner** enous (ell liveryema Anc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/MedIcal ast attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown this certificate has been signed trail director, page 2 should be det 23e. Did tobacco use coatribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20000 2 No 1 Yes 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No Certification; To 3□ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide the Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 32. Pegistrat's Signature 31. Date filed (Month, Day, Year) State MAY 04 2004

DHMH 17 Rev 1/2001

Registrar

marke.

State of Maryland / Department of Health and Mental Hygiene

			Clair of Maryland / De	Certificate of L	Death	Re	g. No. 200	4	5673
	D. 121		1. Decedent's Name (First, Middle, Lest)			2. Date of Death Month			ime of Death
	Physicia /Medic		Mary Margaret Haupt			May	$\overset{\text{Day}}{3}$ , $20\overset{\text{Ye}}{0}$		2:41AM
	Examin		4a. Facility Name (If not institution, give street and number)	4	b. City, Town, or Lo		4c. County of E		
			Waldorf Healthcare Center		Waldorf		Char		
	<sub>c</sub> Funeral		5. Social Security Number  178-10-9871  6. Sex 1	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			State or Foreign
	Director		178-10-9871 86 118 Usual Residence of Decedent			March 10	1,1910 PE	ennsyl	vania
	/land		10a. State 10b. County 10c. City, Town of	or Location				10d. Ins	side City Limits
	Mar	to	MD Charles Waldorf	=				1[	☐Yes 2√ No
	uth with the Marylan 23a or 28a-f show ast be notfilled at	irec	10e. Street and Number	10f. Zip Code		10	g. Citizen of Wha	t Country?	
	h wit	aiD	5021 Bryantown Road	20617		Direct Control	U.S.	Α.	
	dead dead	Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp In. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	American Ind Vhite, etc.	lian,
2	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Madical Exteries must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2₹∑No	1 ☐ Yes 2 ဩXNo		, , , ,	Specify:	vinto, oto.	
0200-6121	ral',	d by	3 \(\frac{1}{2}\) Wildowed 4 \(\price \) Divorced Year or Dates:					White	
ភ	n 72 h	Be Completed	15. Decedent's Education 16a. De (Specify only highest grade completed)	ecedent's Usual Occupa Give kind of work done of fe. DO NOT us <b>e</b> retired	ation during most of work	ing 1	6b. Kind of Busine	ess/Industry	
7	vithir ne. han	mp	Elementary/Secondary (0-12) College (1-4or 5+)		)				
Maryland 21	filed v Hygie rther t	ပိ	12 Book 17. Father's Name (First, Middle, Last)	kkeeper	18. Mother's Name		Trucking	5	
au	a d a d		William Fleming		Delilah		,		
5	should be nd Menta marked umatic ev	٦		failing Address (Street a			City or Town, Sta.	te. Zin Code	)
<u>8</u>	2 a 2 a			21 Bryantow					
a)	ss 1 and of Health item 27 other to		20a Mathod of Disposition 20b. Place of D	isposition (Name of		Date 2	Oc. Location - City		tate
2	Pages nent of I int: If ite		1 □ Burial 2 ☒ Cremation 3 □ Hemoval from State	crematory or other plac Leld-Echols		lay	1h 1 - 4-4 -		MD
	artme		21. Signature of Funeral Service Licensee	22. Name and Addres					
ñ	permit. Pages Department of Important: If it any injury or c once.		Jan 1 Doct John	30195 Thre					
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.					Appro	oximate
	Physician				•			Interv Onse	ral Between et and Death
)	/Medical		Immediate Cause (Final disease or condition resulting in death)	is				117	NK
	Examiner		disease or condition a. Due to (or as a cor	nsequence of):					
	n #	ner	- TNECTED	LEFTI	3F10W	KNEE	STUI	np 1	WIC
	cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, Due to (or as a con					Ĭ	
Š,	e exe sian a vurial-	Ð	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conditional conditions).					1	
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S X	leath certifica attending pt d for use as t	2	d						
gox	atten atten for us	Physician/						-	
j	he de the d	ysic	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause give	en in Part !.		acco use contrib		
٠ <u>.</u>	requires that the death certificate be executed then signed by the attending physician and hould be detached for use as the bunal-transit		DIABETES			1 ⊔ Yes	s 2□No 3□	Probably	Unknown
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2	sicien: The law s certificate has b director, page 2 s	Completed				1 ☐ Yes	2 1 No	1 ☐ Yes	
	n: Ti fficate or, pe		25. Was case referred to medical		26 Place of Deat	(Check only one			
	Physicien: rthis certific rrai director,	o Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Othe	or:	me 5□Residen		Specify)	
ō	y Phys er this eral dii	H	27. Manner of Death 28a. Date of Injury 28b. Tim	ne of 28c. Injury		28d. Describe hov		. ,,	
0	Attending F or death. ector: After by the tuner	atio	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation		Yes 2□No				
DIVISION OF	i or Attend after death Director: / d in by the i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Stre City or Town,	et and Number of State)	r Rural Route	e Number,
5	taion rsaft aiDii	Ce							
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	edical	29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/o						ause(s)
	the I	Med	one) and manner stated.  29b. Signature and titla of certifier	29c, License	number	20	d. Date signed (M	onth. Dav. Y	'eer)
	Veit Col		255. Signature and title of certifier	TU	111021	Λ.	144 M	2 7	NO LI
			1 28/000	D T	772	2 1	171 0	2 41	
1	BIO		30. Name and address of person who completed cause of death (tem 23a) (Ty	(pe, Print)	ucmell	UN CT	VALDO	RFM	20602
4	) IU Sta	to	31. Date filed (Month, Day, Year) 5 2004	· Species	~(C 1. 1/2 )(	- J	4		
8.5	Registr		MAY 0 5 2004	1					

			For State Registrar	State of Ma	aryland / Depa	artment of rtificate of			giene Reg. No.	/ 11111	15674
			1. Decedent's Name (First, Middle, Last	)				2. Oate of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Willis R. Inman	Jr.				May	4	2004	8:00P <sup>M</sup>
7	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Oe	ath	4c.	County of Death	
			Holy Cross Hospita			Silver		m   - 0 · (D)		ntgomer	
	Funeral		5. Social Security Number 6. Se	x XM 2□F 7.Agi	a (In yrs. last birthday) 72 Yrs.	If Under 1 Yea Months Days		in. (Month, Da	y, Year)	Cour	
	Director		571-40-0218 Usual Residence of Decedent		73 Yrs.			July 28	5, 15	30   Cal:	ifornia
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Marylan -f ehow find ut	to	DC		Washingto	n D.C.					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Cour	ntry?
	h witl 23a o 81 Le		1713 S Street NW			20009			USA		
	deat ems	by Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Oecedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-	14. Race - Americ Black, White,	
9	or It	E.	1 XNever Married 2 Married	1 Tes 2 1	w(unk.)	1 ☐ Yes 2 🗓 No				Specify:	
00	urel',	q p	3 Widowed 4 Divorced	Year or Dates:	160 Dans	dantia Unival Ossi	unation.		10h Kir	Whit nd of Business/In	
21215-0036	within 72 hours after death with the Maryland sne. than "naturet", or Items 23a or 28a-f ehow the Medical Examinar must be inclined at	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of v ed)	vorking	TOD. KII	ild of programessylli	Gustry
12	withi ene than	E C	Elementary/Secondary (0-12)	College (1-4or 5	i+)	tising M			Pub1	ishing	
	Hygi Hygi other ent, I	a)	17. Father's Name (First, Middle, Last)					lame (First, Middle			
an	lental lental rked ic ev	To B	William R. Inman S	r.			Martha	Forsythe			
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehov item 27 is marked other than "naturel", or Items 23a or 28a-1 ehov other treumatic event, Ite Medical Evanther must be multified at		19a. Informant's Name/Relationship (7)	rpe Print) mestic	19b. Maili	ng Address (Stree	et and Number or	Rural Route Numb	er, City o	r Town, State, Zip	Code)
	and 2 alth a 127 i	1	William Kummann/ <sup>Pā</sup>	rtner			NW Wash	ington, I			
ore	of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ I	Removal from State		matory or other pi	1 1161	y 7,	20c. Lo	cation - City or To	own, State
<u><u>Ĕ</u></u>	Pag ment ant: I ury o		`4 □ Donation 5 □ Other (Specify,		W. Arund	el Crema	tory 2	004	Oder	iton, Mai	ryland
Baltimore,	permit. Pages Department of H Important: If its any Injury or or once.		21. Signature of Funeral Service bicens	see ()		2. Name and Add		ion Servi	ce	P.O. Box	× 784
ш_	205 29	7 4	Devery J. H.	exercle	<u> М01251 в</u>	everly L	. Heckro	tte, P.A.	C1a	rksville	x 784 - MD 21029 Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only company to the control of the control	ne cause on each li	ne.	ter the mode of dy	ying, such as care	nacoi respiratory a	11651,		Interval Between Onset and Death
	Prysician	e i	Immediate Cause (Finaf disease or condition resulting in death)	a. Pneumon							
	/Medical Examiner			·	a consequence of):						
		-	Sequentially list conditions, if any, leading to immediate	b. Metasta Due to (or as	tic Squamo a consequence of):	us Cell	Cancer				
	uted Insit	m	Cause (Disease or injury	c. Prostate	e Cancer						
ć	be executicien and burial-trai	Exa	that initiated events resulting in death) Last		a consequence of):						
760,	0 5 0	cai Examiner		d							
89	leath certificate attending phys for use as the	Medi	IF FEMALE:								
Вох	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	⊒Ectopic pregnan	ісу		2	23d. Date of delive Month	ery Day Year
	0 00 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)	<u> </u>				
P.0	that the ed by th detache	Phy	Part II. Other significant conditions co	intributing to death h	ut not resulting in the I	inderlying cause o	oven in Part I.	23e. Did t	obacco u	se contribute to the	he cause of death?
ds,	9 P	by	Tatti. Othor significant contains of	and butting to obtain t	at the total and the	g casso ş	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 🗆	Yes 2[	□No 3□Prob	oably 4 ∰Unknown
Ö	w requir been si should	etec						24a. Was	20	24h Wara auto	ppsy findings available
Records,	e la has	Completed						<ul><li>auto</li></ul>		prior to co death?	mpletion of cause of
a	icien: The l certificate ha rector, page	e Co	25. Was case referred to medical				OC Place of I	1 ☐ Yes Death (Check only of		1 ∐ Yes	2 No
Vital		8	avaminer?	Hospital:	ent 2 ☐ ER/Outpatie	nt 3□ DOA	\thean	g Home 5 ☐ Resi		3 ∏Other (Specif	(v)
o		n: To	27. Manner of Death	28a. Date of Inju		and the same of th		28d. Describe			,,
io	Attending I r death. ector: After by the funer	atio	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) fnjury		☐Yes 2☐No				
Division	Atte er deg ecto by th	tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	288. Prace of in	ury - At home, farm, si c. (Specify)	reet, factory, offic	е	28f. Location ( City or To			al Route Number,
Ö	tel or s afte el Dir ed in	Certification;		January, or							
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1X Certifying Phy (Check only 2 Medicel Exam	sician: To the best	of my knowledge, dea f examination and/or in	th occurred at the	time, date and play opinion, death of	ace, and due to the courred at the time,	cause(s)	and manner as s	tated. o the cause(s)
	the hin 24 the F	Medi	one)	and manner st			nse number			e signed (Month,	
	To To	~	29b. Signature and title of certifier	1000	.0011 61	230. 1.108	DA-7	-			
	101		Mutt	e Ill	ulle le	WO D	0000	05	мау	5, 2004	
9/	NO		30. Name and address of person who o				41 C	nduc 1m	2001	0	
	Sta	te	Kristie Newcele M 31. Date filed (Month, Day, Year)	3 Registr	Forest G1 rar's Signature	en Ka. S	river Sp	ring, MD	∠U91	.U.	
	Registi		MAY 0 7 200	14 Claren	rar's Signature	and I					

			For	State of N	/larylan	d / Depa	artment of H	lealth a	and Me	ntal Hy	giene	2001	1 (***	C 7 5
			1 - State Registrar			Cei	rtificate of l	Death			109.110	2004	10	675
	Physicia	an	Decedent's Name (First, Middle,	Last)					2.	. Date of Dea Month	ath Day	y Year	3. Time o	
	/Medic		John George Joch							pril :				40 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution,	give street and numbe	ar)		4b. City, Town, or		of Death			. County of Death		
			Casey House  5. Social Security Number  6	Sex 7.	Age (In vrs.	last birthday)	Rockvill If Under 1 Year	e If Under 2	24 Hrs.   8	Date of Birt		ontgome		or Foreign
	Funeral Director		143-48-9064	1 <b>X</b> □M 2□F		g Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)		place (State intry) York	or r oroigin
	ש		Usual Residence of Decedent							<u>ود عط</u>	177	J NEW		
	arylan show	_	10a. State 10b. County			y, Town or Lo							10d. Inside C	City Limits s 2 ☐ No
	death with the Maryland ms 23e or 28e-f show	Directo	Virginia		ATE	xandri							1275	- 2 1140
	with the or 2	吉	10e. Street and Number	1 0	"1006		10f. Zip Code					tizen of What Cou	intry?	
	s 23	Funeral	260 South Reynol	ds Street 12. Was Decede			22304	isnanic Oric	nin? (Specif		USA_	14. Race - Amer	ican Indian	
	r Iten	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?		Was Decedent of H f Yes, specify Cuba		, Puerto Ric	an, etc.)		Black, White		
2	ral', o	l by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 □ Yes 2N□ No	Specify:				Specify: Whi	te	
21215-0036	be filed within 72 hours after death with the Marylan that Hygione. And Hygione. And other than anatural; or ltems 23e or 28e-f show avent, the Macrical Examiner must be multified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most	t of working		16b. K	ind of Business/I	ndustry	
V	within ne. hen	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)									
N	e filed within al Hygiene. I other then vant, the Ma		17. Father's Name (First, Middle, La	1st)		Syste	ms Engine		er's Name (F	First, Middle.		ense Cor	tracto	or
Maryland	Suld be I Mental I arkad o atic ava	o Be	William Wellingt		ool. b	hem			,	lyn Ba		,		
<u></u>	2 should be and Mental is marked of raumatic av	ဥ	19a. Informant's Name/Relationshi		4 000		ng Address (Street a			<del>-</del>			p Code)	
Š	77		Christopher W. J	ochem/ bro	ther	286 W	estville	Avenu	ıe,Wes	t Calo	dwe1	1, NJ 07	006	
Š.	as 1 a of Hei itam		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3		20b. F	Place of Dispo	sition (Name of natory or other place	:0)	May 3	Ð	20c. Lo	ocation - City or T	own, State	
Ĕ	Page ment ant: If ury or		'4 □Donation 5 □ Other (Spe		ie.		1 Cremato		2004	I	0de	nton, Ma	ryland	1
Baitimore,	permit. Pages 1 and Department of Healt Important: If Itam 2 any injury or othar once.		21. Signature of Funeral Service Li		4	22 G	Name and Address	ss of Facility  Crem	y nation	Servi	ice	P.O. Bo	× 784	
	90 E @ 0		Beverly I		te mo		oing Home everly L.					arksvill		
	R		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	ine deat	n. Do not ent	er the mode of dyin	g, such as	cardiac or n	espiratory ar	rrest,		Approxima Interval Be Onset and	tween Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Gliobla			forme						6 mc	nths
	Examiner			Due to (or	as a conseq	uence ot):								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	uence of):								
	cuted nd ransit	Examiner	that initiated events	c										
/60,	be executed ician and burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):								
2/89	ys ys	dicai		d										
	certifica Iding ph	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	ancy						23d. Date of deliv	erv.	
ROX	the death y the atter ached for u	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnan			Ectopic pregnancy Other (specify)					Month	Day	Year
o.	t the c by the	hysi	9 Unknown	9□ Unknowr	1									
S,	The law requires that the de ite has been signed by the page 2 should be detached	ьу Р	Part II. Other significant condition	s contributing to death	n but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to		use contribute to		
Kecords,	equir sen si ould I								'	1 🗆 Y	res 2	X No 3□Pro	bably 4 🗆	Unknown
ပို	2 8 8	ompieted								24a. Was autop	SV		opsy findings impletion of	available cause of
		Con								perfor	rmed? 2 ŽNo	death? 1 ☐ Yes	2 □ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth			Check only o		**		
Ö	Phys r this ral dii	. To	1 Yes 2 XNo 27. Manner of Death	28a. Date of I	niury	ER/Outpatier 28b. Time of	f 28c, Injun	v at		5 Resid		6 KiOther (Special Control of Con	<sub>fy)</sub> nospi	.ce
O	Attending in death. actor: After by the fune.	itior	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	Worl	k? Yes 2.∐1	No					
Division	al or Attending PP s after death. al Diractor: After the ed in by the funeral	ifice	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of	Injury - At he		eet, factory, office		28f	Location (S City or Tow		nd Number or Rui	al Route Nur	nber,
5	rs after al Dire	Certification:	Thomas and the same and the sam	Dullaling,	ote. (apoon	<i>y</i> /				ony or row	,, olulo		11111111	
	To the Hospital or within 24 hours after To the Funaral Dii completely filled in	Medical		Physician: To the be xaminer: On the basis and manner	of examina									s)
	To tha within 2 To the complei	ž	29b. Signature and the of certifier	11/2			29c. License	e number	10	,	29d. Dat	te signed (Month,	Day, Year)	
			Most	11 C			Di	112	18		4	130/0	4	
6	0.0		30. Name and address of person w					7 =			1	,		
	Sta	te	Charles Harrison 31. Date filed (Mark Day, 1992)	M.D. 600	1 Mun strar's Signa	caster	Mill Rd.	Rock	ville	, MD 2	085	5		
	Registr		MAY U 5	2004	we ,	caster	1846							

	. FOI	partment of Health and Menta ertificate of Death	al Hygiene Reg. No. 2004   15676
Physician	Decedent's Name (First, Middle, Last)  Mary Virginia Lepson		e of Death nth Day Year 105A M
/Medica Examinei	4- F- Wh. No W Lockwise of a street and auchar)	4b. City, Town, or Location of Death Prince Frederick	4c. County of Death Calvert
Funeral Director	5. Social Security Number 220 07 3116 6. Sex 7. Age (In yrs. last birthda 1 M 2 F 94 Yrs.	Months Days Hours Min. (Mo	e of Birth Page (State or Foreign Country)  9. Birthplace (State or Foreign Country)  Waryland
Maryland -f show	10a. State 10b. County 10c. City, Town or	Location Frederick	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the Mar 23a or 28a-f st rat be notified		10f. Zip Code 20678	10g. Citizen of What Country? United States
VICE 5-UUSD  Within 72 hours after death with the Maryland Jiene.  I'm Medical Exacting Entrates and 28a-1 show  The Medical Exacting Entrates in Difficult  Completed by Entrates in Director	3 ☑ Widowed 4 □ Divorced	8. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 6 1 ☐ Yes 2점 No Specify:	s or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
d Z IZ I D-UU30 filed within 72 hours at Hygiene. ont, the Medical Eneral ont, the Medical Eneral	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  home	edent's Usual Occupation re kind of work done during most of working . DO NOT use retired) emaker	16b. Kind of Business/Industry Own home
DG file tal Hyg d othe	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Edith Grier	Middle, Maiden Sumame) CSON
Mar nd 2 sh lith and 27 is m r traum	19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Rural Route Solomons Is. Rd. Prir	20678
S S S	'4 □Donation 5 □Other (Specify)  St. Paul	ematory or other place) 's Cemetery May 4 2004	20c. Location - City or Town, State Prince Frederick MD
Bartimo permit. Page Department important: If any injury or		22. Name and Address of Facility Rausch 105 Broomes Is. Rd. Por	n Funeral Home ct Republic MD 20676
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac or respir	atory arrest, Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions b.		
oa / bu, icate be executed physician and s the burial-transit	resulting in death) Last   C. Due to (or as a consequence of):		
death certif		i □Ectopic pregnancy i □ Other (specify)	23d. Date of delivery Month Day Year
S, es ti	Part II. Other significant conditions continuing to death out not resulting in the	underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death?  1  Yes 2 2 No 3 Probably 4 Unknown
The The page			a. Was an autopsy and 24b. Were autopsy findings available prior to completion of cause of death?  JYes 2□No 1□Ves 2□No
Vita sician: certific lirector	25. Was case referred to medical examine?  1 Yes 2F No Hospital: 1 Inpatient 2 FR/Outpatient	26. Place of Death (Checkent 3 DOA Other: 4 Nursing Home 5	k only one)  Masidence 6 □Other (Specify)
ding After		of 28c. Injury at 28d. De	scribe how injury occurred
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After templately filled in by the funeral Madrical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. Loc City	eation (Street and Number or Rural Route Number, y or Town, State)
To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier (Check only one)  1   ☐ Certifying Physician: To the best of my knowledge, de. 2  ☐ Medical Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
To t To t	> farling	29c. License number  D @ 5 22 4 2	29d. Date signed (Month, Day, Year)  4/30/2004
8	30. Name and address of person who completed cause of death (Item 23a) (Type J. John Barth, III M.D. Prince	e Frederick, Maryland :	20678
State Registra	and a contract to the	Sperlie	

Xallillel	4a. Facility Name ( 6127 I 5. Social Security I 577-38-5 Usual Residence of 10a. State  MD 10e. Street and No 6127 11. Marital Status 1 Never Mai 3 Widowed  (Spe Elementary/Sec 9 17. Father's Name David 19a. Informant's  Linda B 20a. Method of D 1 XBurial 4 Donation	D160  of Decedent  10b. County  Prince G  umber  Lamont Dri  med 2 Married 4 Divorced  15. Decedent's Educity only highest grade condary (0-12)  a (First, Middle, Last)  Wolfe  Name/Relationship (7)  aldwin/Dau  isposition 2 Cremation 3 D	eorge S  Ve 12. Was Decede Armed Force 1 Yes, Give Year or Date completed)  College (1-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4	Age (In yrs. la: 74  10c. City,  int Ever in U.S as?  XNo	Town or Loca  13. Will 16a. Decede (Give ki iife. DO	New If Under 1 Months  Ation  New 10f. Zip of the control of the c	T Carro Code 20784 ent of Hispanify Cuban, Me R No Spill Occupation k done during e retired)	ollton nder 24 Hrs. urs Min.  Dllton  ic Origin? (Spe exican, Puerto ecity: g most of work.	ecify Yes or No Rican, etc.)	4c. C Pr 7, Year) 5, 19	9. Birth Color 29  an of What Co  USA 4. Race - Ame Black, White Specify: Wd of Business/	polace (State or For unity) PA  10d. Inside City Lin 1  Yes 2  Unity?  nican Indian, e, etc.  hite Industry
tem 27 is marked other than "natural", or itema 23e or 28e-f show a but other traumatic event, the Medical Examinar must be inclined at on the traumatic event, the Medical Examinar must be inclined at other traumatic event, the Medical Examinar must be not at the property of the model of the completed by Funeral Director	5. Social Security   577-38-9 Usual Residence of 10a. State  MD 10e. Street and No. 6127 11. Marital Status 1 Never Mai 3 Widowed  (Specific Security   17. Father's Name David 19a. Informant's  Linda B 20a. Method of D 1 XBurial 4 Donation	Number  6. Ser  160  10b. County  Prince G  umber  Lamont Dri  med 2 Married  4 Divorced  15. Decedent's Educity only highest grade condary (0-12)  a (First, Middle, Last)  Wolfe  Name/Relationship (7. Staldwin/Dau isposition  2 Cremation 3 D	eorge's  Ve  12. Was Decede Armed Force 1   Yes   2   If Yes, Give Year or Date  (cation le completed)  College (1-4-	74  10c. City,  ont Ever in U.S as?  [X]No	Yrs.  Town or Loca  13. Was lift of the control of	as Deceding Special Sp	V Carro	nder 24 Hrs. urs Min.  D11ton  ic Origin? (Spexican, Puerto ecity:	ecity Yes or No Rican, etc.)	7, Year) 5, 19  10g. Citize 16b. Kind	9. Birth Color 29  an of What Co  USA 4. Race - Ame Black, White Specify: Wd of Business/	nplace (State or For unity) PA  10d. Inside City Lin 11 Yes 2 C unitry?  incan Indian, e, etc.  Inite Industry
tem 27 is marked other than "natural", or itema 23s or 28s-f show to be possible traumatic event, the Medical Examinar must be notified at the possible traumatic event, the Medical Examinar must be notified at the possible traumatic event. To Be Completed by Funeral Director	577-38-5 Usual Residence of 10a. State  MD 10e. Street and No. 6127 11. Marital Status 1   Never Mar. 3   Widowed  (Spe. Elementary/Sec. 9 17. Father's Name. David 19a. Informant's  Linda B 20a. Method of D 1 XBurial 4   Donation	D160  of Decedent  10b. County  Prince G  umber  Lamont Dri  med 2 Married  4 Divorced  15. Decedent's Educify only highest grad  condary (0-12)  a (First, Middle, Last)  Wolfe  Name/Relationship (7  saldwin/Dau  isposition  2 Cremation 3 D	eorge's  Ve  12. Was Decede Armed Force 1	74  10c. City,  ont Ever in U.S as?  (XNo	Yrs.  Town or Loca  13. Was lift of the control of	Months  ation  New  10f. Zip of the control of the	T Carro Code 20784 ent of Hispanify Cuban, Me R No Spill Occupation k done during e retired)	D11ton  ic Origin? (Spenican, Puerto ecity:	ecity Yes or No Rican, etc.)	10g. Citize	29  an of What Co  USA 4. Race - Ame Black, White Specify: W d of Business/	PA  10d. Inside City Lin  1  Yes 2  untry?  ncan Indian, e, etc.  Chite Industry
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any injury or other tra	20a. Method of D 1 XBurial	isposition	ghter						al Route Numb			
any injury or off	1 XBurial  1 □ Donation	2 Cremation 3 🗆		20h Pi	11620	Rive	ershore	e Drive	20c. Loc	c. Location - City or Town, State		
any injury o	` 4 □Donation		20a. Method of Disposition  20b. Place ceme  20b. Place ceme							Cheltenham, MD		
eny in	21 Cianatura of	'4 □Donation 5 □Other (Specify) Cheltenh										
	21. Signature of Eureral Service Ucensee  22. Name and Address of Fa  PO Box 430,  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such						Dunki	rk, MD_	20754	l Funer	al Home,	
burial-transit ability in burial-transit and Examiner	d										391	
or use as the	IF FEMALE: 23b. Was deced in the past 1 □ Yes 9 □ Unkno	F FEMALE:  3b. Was decedent pregnant in the past 12 months?  1   Yes 2* BNo 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 5   Other (specify)   9   Unknown										
be o	artin onnor org	Part II. Other significant conditions contributing to death but not resulting in the underlying ca						ven in Part I. 23e. Did tobacco			o use contribute to the cause of death 2 No 3 Probably 4 Unkr	
page 2 should t									24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings a prior to completion of call death?  1 Yes 2 No 1 Yes 2 No			completion of caus
Be Be	25. Was case re examiner?	examiner?							ath (Check only one)			
al dire			28a. Date of Injury 28b. Time of 28c. Injury at					Home 5 Residence 6 ☐Other (Specify)  28d. Describe how injury occurred				
To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification; To Be Comp	1 Natural 2 Accider 3 Suicide	5 ☐ Pending investigation 6 ☐ Could not b	(Month, Day Year) Injury Work?    Month, Day Year)   Injury   Work?   1   Yes 2   No					28f. Location (Street and Number or Rural Route Number City or Town, State)				
led in by		de determined	buildin	ig, etc. (Specif	<b>y</b> )			data and size				as stated
he Funar pletely fill edical	29a. Certifier (Check only one)	f⊟ Certifying Pi 2  Medical Exa	hysician: To the miner: On the ba and mann	isis of examina	wiedge, death ation and/or inv	vestigation	n, in my opinie	on, death occu	urred at the time	, date and	piace, and de	20 (0 (1/0 02000(3)
comp	≥ 29b. Signature	and title of certifier	: 01	-0		29	c. License nu	umber	***	290. Da	te signed (Mor	nth, Day, Year)
	1	Maddress of person who	Lu	W.	m (12a) (Times	Priet'	2521	176	NO		5///	04

			For	State of	Maryland					and M	ental Hyg	jiene	2001	15070	
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)					rtificate of Death Re					eg. No. CUU4 156 8		
	Physicia		_		т.			T			Month	Day	Year	12:25 p <sup>M</sup>	
	/Medic	al	James 4a. Facility Name (If not institution	Bruce		ons,	4b. City.	Jr. Town, or	Location of		April	29 4c. (	2004 County of Deatl		
	Examin	er	3930 Bayside Ro	_	,				eake 1		ı		Cal	vert	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I	ast birthday)	If Under Months				8. Date of Birth (Month, Day	Year)	9. Birth Co.	nplace (State or Foreign	
	Director		238-14-5640	1 <b>∑</b> M 2□F	86	Yrs.	IVIOITIIIS	Days	110013	14141.	Sep 4,	191		endship, MD	
	pu 🖈 🖫	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Lo	ocation							10d. Inside City Limits	
	Aaryli f eho						Che	care	eake 1	React	1			1 ☐ Yes 2X No	
	death with the Marylan ns 23e or 28e-f ehow	Director	MD Calve  10e. Street and Number	I.C			10f. Zip	_	are_	ocaci		l 0g. Citiz	en of What Co	untry?	
	3e or		3930 Bayside Ro	ad			207	732					USA		
	death	Funeral	11. Marital Status	12. Was Deced		S. 13.		lent of H	ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, White		
ထ္	or Ite	正	1 Never Married 2 Marr	ied 1 1 Yes 2	No		1 ☐ Yes 2		Specify:				Specific		
	in 72 hours after des n'neturel', or Items	d by	3 Nidowed 4 □ Divorced		es: 1945		dont'e Heus	I Occup	ation			16h Kin	w1.	nite	
21215-0036	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23e or 28e-f show ant, Ite Marical Examinar must be notified at	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)									,			
212	with jiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+) stear			mfitter					C	tion		
٥		To Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden :	Sumame)		
<u>Xa</u>	2 should be f and Mental I le marked o' reumatic eve		James Bruce	Lyons,	Sr.				Min		Lavin		Long		
Maryland	Cl — @		19a. Informant's Name/Relations				-				l Route Numbe				
	1 and Health em 27 ther tr		Judith A. Leona 20a. Method of Disposition	ard, daugh	20b. P	lace of Dispo	osition (Nan	ne of			sapeake		cation - City or	20732 Town, State	
nor	00-		1 ⊠Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S		tate I	emetery, cre. • Memo	-			05-03	-04	Dunk	kirk, M	)	
Baltimore,	7 5 4 5		21. Signature of Funeral Service		1 00		2. Name an			_	-	-uz	LLLILY		
B	Depar Impo any ir		William"	R. Graz	4	I	Rausch	ı Fui	neral	Home	e, P.A.	, 0	wings,	MD 20736	
		E A	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):										Interval Between		
	Pnysician		Immediate Cause (Final disease or condition	<	Cong.	estive	e He	er 1	-60	4./0-	~			2 - 3	
	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):									
	Lxanime	_	Sequentially list conditions, if any, leading to immediate	b. Due to (o	or as a conseq	uence of).									
	ted nsit	Examiner	Cause (Disease or injury	\$ 0.00.00	, 25 2 5511554	201120 01,									
	execu n and ial-tra	Exar	that initiated events resulting in death) Last  Due to (or as a consequence of):												
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	ical													
9	ng phras th	Medi	IF FEMALE:	T			-					-/-			
Вох	leath certifica attending ph for use as the	an/I	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy							2	23d. Date of delivery  Month Day Year				
	the a	ysici	1   Yes 2   No 9   Unknown   9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   Yes 2   No 9   Unknown   1   Yes 2												
P.0	that the di ed by the detached	by Physician/Med								23e. Did to	d tobacco use contribute to the cause of death?				
sp.	uires that signed t										1 U Y	es 25	ZNo 3□Pr	obably 4 DUnknown	
Vital Records,	w requir s been si should	Completed									24a. Was		24b. Were at	itopsy findings available completion of cause of	
Re	The lay ate has bage 2	omp									autop perfor	med? 2 No	death?	2 No	
ita		BeC	25. Was case referred to medical 26. Place of Death (Check only one)												
of V	Physicien: this certific ral director,	To	examiner? 1 Yes 2 No			ER/Outpatie		-	4 LIN	-	me 5 Aesic			cify)	
n c	ding P. After t funera	on:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work? 28d. Describe how injury occurred 1 Treatural 5 Pending (Month, Day Year) Injury Work?												
Division	l or Attending after death. Director: After I in by the fune	Icat	3 Suicide 6 □ Could	not be 28e. Place	of Injury - At h	ome, farm, si			.03 2		28f. Location (S	Street and	d Number or Ri	ural Route Number,	
Di≤	after Direct	Certification:	4 Homicide determ	buildin	g, etc. (Specil	<b>(y</b> )		,			City or Tou	m, State)	)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyi	ng Physician: To the i	best of my kno	wledge, dea	th occurred	at the til	me, date a	nd place,	and due to the	cause(s)	and manner as	s stated.	
	the H nin 24 the F nplete	Medical	one)	and mann					e number				e signed (Mont		
	To Too	-	29b. Signature and title of certific	MalA	IN	10	23	-	181	9		M			
												, 2404			
1.	5+1		M & ++h		1alta	/	132	. 17	ulid	CP	CT.	5.	一、木	211	
		ate	31. Date filed (Month, Day, Year	0 3 2004	egistra s Signa	ature		•							
	Regist	rar	mA1	0 0 2004	MARCH	w K	600	45							

			1 - For State Registrar	State of Man	yland / Depa <i>Ce</i>	artment of F	lealth and Death		giene 200	14 15679		
	Physic	ian	Decedent's Name (First, Middle, Last			-		2. Date of De Month	ath Day Ye	3. Time of Death		
	/Medi	cal	Lloyd William  4a. Fecility Name (If not institution, give			45 00 7		April	28 200	4 11:45 ρ <sup>M</sup>		
	Exami	ner	Mallard Bay Care	*		4b. City, Town, o		eath	4c. County of E			
	Funeral		5. Social Security Number 6. Se	x, 7. Age (li	n yrs. last birthday)	Cambr	If Under 24 H	Irs. 8. Date of Bir		nester Birthplace (State or Foreign Country)		
	Director	Н	219-34-3764	M 2□F	75 Yrs.	Months Days	Hours M	April (Month Da	th Year) 9.	Maryland		
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits		
	ne Marylar 8a-f show	ctor	MD Dorches		1 □ Yes 2 No							
3	th with the 23s or 2	al Dire	10e. Street and Number 5984 Shiloh Chur		10f. Zip Code	21643	10g. Citizen of What U.S.A.	-				
) 980	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show Ita Medical Examiner must be ricitlified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		mencan Indian, hite, etc. White		
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup	ation	working	16b. Kind of Business/Industry			
121	vithin han *	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	4)	voixing				
9	be filed within 72 ho lal Hygiene. d other than "natu event, the Medical		17. Father's Name (First, Middle, Last)		111	achine op		lame (First, Middle,	power pl	ant		
Baltimore, Maryland 21215-0036		To Be	Adam Metz					ie Langfor				
Man	2 m m 2		19a. Informant's Name/Relationship (Ty Florence Metz	rpe, Print) wife		Box 127			or, City or Town, State	e, Zip Code)		
-	other tre		20a. Method of Disposition		20b. Place of Dispo		_ ·	Date	21643 20c. Location - City	or Town State		
Õ			1 Burial 2 □ Cremation 3 □ P  '4 □ Donation 5 □ Other (Specify)							Market, MD		
alti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License		22	. Name and Addres	ss of Facility	Thomas Fu	neral Hom	e P.A.		
_	9 Q E # 9		23a. Pert V Enter the disease, or compli	~				Cambridge	•	13		
	Physician and Medical Examiner transit the private transit the private transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that infitted events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
.O. Box 6	the death certify the attending Iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year			
rds, P	quires than signed to all the det	þ	Part ii. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.									
	iicien: The law requires that certificate has been signed b rector, page 2 should be deta	Completed	25 W						prior to death?			
Vital	ysicien: is certific director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 ER/Outpatient	3 DOA Othe	-	eath Check only on				
Division of	ding Ph th. : Alter th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28c. Injury Work	DA   Other 4							
á	i gite o	Certification:	3 Suicide 4 Homicide  4 Homicide  4 Homicide  4 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural I building, etc. (Specify)							Rural Route Number,		
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occ	ce, and due to the ca curred at the time, d	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)		
)	To the complet	×	29b. Signature and title of deriffer MD 29c. License number DO056659 4/30/04  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUHAMMAN BOOK SOUTH BOOK ALL SOU BUREARS T, COMBRID46 MD - 2/0									
			30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type, E	Print) URORA	-ST,	COMBRI	045 1	70-2/6/3		
	Sta Registr	te	31. Date filed (Month, Day, Year)  HTK 3 0 200	4 32 Registrar's S	Signature &	ille)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 28, Nelson Martin April 11:10 P 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 11X M 2□ F 579-03-3347 88 March 12, 1916 Washington Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. Count 10a State No Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 USA 6083 B Thoroughbred Court 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 1942— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 200 Married 1 ☐ Yes 2 ☑ No Specify: Yes, Give 'ear or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 1943 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Naval Hydrographic Elementary/Secondary (0-12) College (1-4or 5+) Oceanographer Office 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martin Elenora Levell Louis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4912 Brentley Rd Camp Springs, Maryland 20748 Louis N. Martin Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 5/5/04 Cheltenham, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility desog. Adams Funeral Home P.A. Aquasco, Maryland MO1323 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiro ton Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 XYes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No MPH) tris autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r then "netural", or Items 23e or 28a-f show the Medical Examiner must be notified at

other

Ith and Mental H
77 is marked of

permit. Pages 1 and 2 should to Department of Health and Mentol Importent: If item 27 is market

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

After thi death.

Physician/Medical Completed by Be 2 Certification:

Examiner Medical

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 27. Manner of Death 29a, Certifier

Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: / completely filled in by the f

State Registrar

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

emboli

28a. Date of Injury (Month, Day Year)

Hospital: 1 ⊠Inpatient 2 ☐ ER/Outpatient

29c. License number D28035

🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3□ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Myotanial Intendin Yes 25
26. Place of Death (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOLIA. MD. BASTRMOHMAD

9135 Pisrataway Road, # 210 CLINTON

2 No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

31. Date filed (Month, Day, Year)

Occusion

1 Natural

2 Accident

3 Suicide

4 | Homicide

MAY 0 5 2004

32. Re

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

		•	For State Registrar	State of M	aryland / Depa	artment of H			giene Reg. No. 211	11. 15001
			Decedent's Name (First, Middle, L.)	ast)				2. Date of Dea	ath	3. Time of Death
	Physici		Peter S	Spiro	Nomikos			April	30 2004	12:45 a M
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death	110111	4c. County of 0	
			8226 Elm Street				oeake Bea	ch	Calv	ert
	Funeral		Social Security Number     6.	Sex 7. Ag 1 ☑ M 2 ☐ F	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h y, Yea <i>r</i> ) 9.	Birthplace (State or Foreign Country)
	Director		052-18-9852 Usual Residence of Decedent	A	94 Yrs.			Jan 16	, 1910	Greece
	land land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 1 sh	to	MD Calver	t		Chesar	oeake Bea	ch		1 <b>X</b> Yes 2 □ No
	r 28a	Director	10e. Street and Number		.1	10f. Zip Code			10g. Citizen of Wha	it Country?
	th with		8226 Elm Street			20732			USA	
	72 hours after death with the Maryland Instural', or Itams 23a or 28a-f show dissi Evantines De notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
98	or It	by Fu	1 ☐ Never Married 2 ☑ Married	1 □ Yes 2 X If Yes, Give	No	1 ☐ Yes 2X No	Specify:		Specify:	
Ö	hours tural'		3 Widowed 4 Divorced	Year or Dates:	162 Dogg	dent's Usual Occup	ation		16h Kind of Busin	white
21215-0036	in 72 in mai	Completed	15. Decedent's (Specify only highest of	rade completed)	(Give	kind of work done of NOT use retired	during most of work	ing	16b. Kind of Busin	essindustry
12	iene.	оше	Elementary/Secondary (0-12)	College (1-4or		ting cont	ractor		construc	tion painting
	illed Hygie other ant,	BeC	17. Father's Name (First, Middle, Lat	st)				e (First, Middle,	Maiden Surname)	CLOSS POLISCES
lar	uld be Aenta rked tic av	To B	Spiro		Nomik	os	Madelin	е		Markoulis
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Numbe	er, City or Town, Sta	te, Zip Code)
	1 and 2 Health tam 27 I		Mrs. Demetra N	omikos, wi		Box 54,	The second secon			732
altimore,			20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac	:e)	Date	20c. Location - City	y or Town, State
ţ			* 4 Donation 5 □ Other (Spec	cify)	St. Deme	CONTRACTOR STATE OF THE PARTY O		03-04	Annapolis	, MD
Bal	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lic	ensee H	_ [[]	2. Name and Addres				
	40200		23a. Part1. Enter the disease, or co	molications that cause					, Owings	MD 20736 Approximate
			shock, or heart failure. List on Immediate Cause (Final	y one cause on each I	ine.		,			Interval Between
	Physician /Medical		disease or condition resulting in death)		treulla	1 16,	· llatio-	`		
	Examiner			Due to (or as	a consequence of):	offer (	1 1 000	cala	Discase	
		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):	J	40000	3000	1013 50	
	outed Id ansit	Examin	Cause (Disease or injury that initiated events	C						
o,	an ar	EX	resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be executed physician and the burial-transit	dical	,	d						
9	ing pl	0 1	IF FEMALE:							
Вох	death certifi e attending f d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 5	Other (specify)				<b>22,</b>
Д	the de		Part II. Other significant conditions	contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
Records,	uires sign Id be	d by	Critica	1 Aosta	~ Stenos	,5		1 🗆 Y	es 2.2 No 3	Probably 4 Unknown
00	w requir been si should	iete						24a. Was a	an 24h Were	a autopsy findings available
Re	The tav	Completed						autop	sy prior med? deati	to completion of cause of h?
Vital		e C	25. Was case referred to medical				26. Place of Deati		2X No 1 1	Yes 2□ No
<u>&gt;</u>	ysic is ce dire	OB	examiner? 1 □ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	t 3 DOA Othe	ar.		ence 6 Other (5	Specify)
ιof		n: T	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju	ay Year) 28b. Time of Injury	28c. Injury Work	at		ow injury occurred	
<u>io</u>	Attanding r death. sctor: After by the fune	atic	2 Accident investigat	on			Yes 2□No			
Division	or Attand after death Diractor: ,	ertification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of in	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	Hospitel or 14 hours afte Funaral Dir tely filled in b	0								
	Hosp 24 ho Funa stely fi	edical	29a. Certifier 1X Certifying I (Check only one) 2 Medical Ex	hysician: To the best aminer: On the basis of and manner st	of my knowledge, death of examination and/or invaled	occurred at the time of occurred at the time of occurred at the time of occurred at the time of time of the time of the time of the time of time of time of the time of time o	ne, date and place, pinion, death occurr	and due to the c ed at the time, c	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	To the Hospitel or I within 24 hours after To the Funaral Dirac completely filled in b	Me	29b. Signature and title of certifier	111	H/h	29c. License	number	2	29d. Date signed (M	onth, Day, Year)
			> /	1 1/0		D 33	3123		05-03-0	14
			30. Name and address of person wh	o completed cause of o	death (Item 23a) (Type,				03 03-0	, ,
	10		Jonathan Lowe			wn Center	Blvd.,	Ste 204,	Dunkirk,	MD 20754
	Sta	_	31. Date filed (Month, Day, Year)	32. Registr	Signature					
2	Registr	ar	MAY	U U LUU4P	BURELAK ! N.	La Company	1			

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

Prince Frederick

Reg. No.

2<sup>0</sup>0 4

Year

14. Race - American Indian, Black, White, etc.

white

20676

23d. Date of delivery

29d. Date signed (Month, Day, Year)

5-2-2004.

Day

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Approximate Interval Between Onset and Death

5 minytes

Year

4c. County of Death

Calvert

Specify:

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

1632 M

2. Date of Death

1

May Month

1. Decedent's Name (First, Middle, Last)

Peter Van Ness

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

**Physician** 

/Medical

**Examiner** 

**Funeral** 

DHMH 17 Rev 1/2001

State

Registrar

85

31. Date filed (Month, Day, Year)

ara.

nurch ton

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

D 50653

Roud

GYAN C. SURANA ROUD Deale MD 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZUNL Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician O'Donnell April 30 2004 7:09 am Patrick Donald /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Anne Arundel Churchton 5773 Broadwater Road If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X**] M 2□ F Yrs Director 579-36-1556 73 Nov 9, 1930 Wash., D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Churchton Anne Arundel 10f. Zin Code 10g. Citizen of Whet Country? 10e. Street and Number 20733 USA 5773 Broadwater Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white ρ If Yes, Give Year or Dates: 1951–71 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Msgt., military security U.S. Air Force 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be ind Mental O'Donnell Catherine Durkin 2 Dominick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Marjorie J. O'Donnell, wife 5773 Broadwater Road, Churchton, MD 20733 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) iny Injury or MD Veterans Cemetery 05-05-04 Cheltenham, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home, P.A., 20736 Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only on a use on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical & months Coronary Examiner Due to (er as a consequence of): 3 years Examiner cancer Metastatic prostate. attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medlcal Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes cerebral vascular accidents ρ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? nis certificete has br I director, page 2 st 2X No 1 ☐ Yes 2 ☐ No 1 TYes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home ome 5. Residence 6 □Other (Specify)
28d. Describe how injury occurred 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) in by the funeral 28c. Injury et Work? 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely file Medical 29a. Certifier (Check only one) 29c. License number (Mavy (and ) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31586 Jamson MD 12 + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA 22 South Greene St 130 NANCY A. DAWSON MD 31. Date filed (Month, Day, Year) 32. Registra Signature State

2004

Glower

MAY 0 5

Registrar

			1 - For State Registrar		State of I	Maryland		artment of			•	giene Reg. No	200	4 15684
}	Physici /Medio Examir	cal ner	1. Decedent's Name (Fit  Wade  4a. Facility Name (If not	Hamp	oton e street and numb			III 4b. City, Town	n, or Location		2. Date of De Month APRIL	Da 2	y Year 6, 2004 County of Dea	
	Funeral Director		CHESAPEAKE I  5. Social Security Numb  237–25–3216  Usual Residence of Dec	er 6. S		Age (In yrs. las	GHT GHT st birthday) Yrs.	ANNAPO If Under 1 Ye Months Da	ar If Unde		8. Date of Birt (Month, Da April 2		NE ARUI 9. Bir 971 Nor	NDEL thplace (State or Foreign ountry) th Carolina
	72 hours after death with the Maryland natural, or items 23a or 28a-f show deal Examinar must be notified at	ector	10a. State 10b Maryland A	nne Ar	undel	10c. City, Nort	Town or Lo	ach						10d. Inside City Limits 1 Yes 2 No
	s 23a or 2	Funeral Director	10e. Street and Number 608 Waln			- F			714				U.S.A.	
9600	ours after de rral', or items LExeminer o	by	11. Marital Status 1   Never Married 3 □ Widowed 4 □		12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	ss? X No		Was Decedent of If Yes, specify C			ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	te, etc.
21215-0036	within ane. than	Completed			ducation ade completed) College (1-40		(Give life.	dent's Usual Oc kind of work do DO NOT use rel Work end	ne during mo ired)		ng		ind of Business Nputer	
Maryland 3	should be filed and Mental Hygie s marked other umatic event, II	To Be C		pton	Price I	I			Jo	yce	(First, Middle, Counci	111		_
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Janey Node  20a. Method of Dispositi	en, si		€	5915	ng Address (Stre Ashbury esition (Name of	Dr.,	Sprin		, VA	22152	
Baltimore,	Page nent c ant: if ury or		1 Burial 2 Cr. 4 Donation 5	emation 3 [ Other (Specif	y) /	cem	opoli	tan Cre	matory	4-28			exandria	
Bal	permit. Departr Importa any inji		f Funera	ya!	9 The	boel	R	2. Name and Ada ausch Fi	uneral	Home	·		ings, M	D 20736
	Physician /Medical Examiner	Je.	23a. Part1. Enter the di shock, or heart fail Immediate Cause (Fina disease or condition resulting in death)  Sequentially list condition if any, leading to immediate.	tre) List only	a. Due to (or	as a consequer	once-of)	er the mode of c	ying, such a	s cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
,820,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injurithat initiated events that initiated events resulting in death) Last	1	c	as a consequer								
.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent prein the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?		2 Fetal de t at time of deat	eath 3[	]Ectopic pregna ] Other (s <i>pecify)</i>					23d. Date of del Month	ivery Day Year
rds, P	es the	by	Part II. Other significan	t conditions	ontributing to deat	h but not resultii	ng in the u	nderlying cause	given in Part	I.	23e. Did to		,	o the cause of death?
Vital Records,	The ate h page	e Completed	25. Was case referred to	n medical				4	00.71			rmed? 2 ☐ No	24b. Were au prior to death?	utopsy findings available completion of cause of
Division of Vi	ing Physicl	Certification: To Bo	examiner?  Yes 2 No  27. Manner of Death  1 Natural  Accident	Pending investigation	40000	Day Year)	Bb. Time o	28c. In	Other: 4 N liury at Vork? Yes 2	lursing Hon	Bd. Describe h	dence (	A contrad D	city) SCENE
Div	pital or Attend burs after death eral Director: /		4  Homicide	Certifying Ph		usup	eala	eet, factory, office Ba	5	s	ONUTED BL	m, State,	Point	iral Route Number, iles Ill Borp Zulles Iight
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical	(Check only one)  29b. Signature/and title	Medicel Exer	niner: On the basis and manner	s of examination	and/or in	vestigation, in m	y opinion, de	ath occurre	d at the time, o	date and	and manner as place, and due e signed (Monti	to the cause(s)
	To with		ALC	M	1/			0	.C.M.E	•			L 27,200	
-	10		30. Name and address of	1-10G	AN				nn Str	eet,	Baltimo	ore,	Maryla	od 21201
	Sta Registr		31. Date filed (Month, D.		3 2004	straff Signatur	H	bout					-	

		1 - For State of Registrar	,	partment of Health and ertificate of Death	Mental Hygie	2001 1000
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last) Frank Ernest Paytas			2. Date of Death Month May 2 200	Day Year 3. Time of Death 4 1800 M
	niner	4a. Fecility Name (If not institution, give street and num. Calvert Memorial Hospit	al	4b. City, Town, or Location of Dea Prince Frederick		4c. County of Death  Calvert
Funer Direct		5. Social Security Number 6. Sex 120 M 2 F	. Age (In yrs. last birthda) Yrs.	/) If Under 1 Year   If Under 24 Hr Months Days Hours Mir		
Maryland -f show	tor	10a. State 10b. County Maryland Calvert	10c. City, Town or I	Leonard		10d. Inside City Limits 1 ☐ Yes 🌠 ☐ No
with the 3e or 28e	i Director	10e. Street and Number 6120 Bandit Al Lane		10f. Zip Code 20685		Citizen of What Country? ited States
d 21215-0036 filed within 72 hours after death with the Maryland Hyglene. wher then "natural", or Items 23a or 28s-f show nn, the Medical Exam or must be millined a	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deced Armed Force  1 Yes, Give Year or Dal	es?	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
Linin 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	(Giv	edent's Usual Occupation re kind of work done during most of wi DO NOT use retired)	orking 16b	. Kind of Business/Industry
<u> </u>	BeC	12 1 17. Father's Name (First, Middle, Last) Frank John Paytas	mi		ame (First, Middle, Maid	
aryland should be and Mental marked o	ြင	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	Louise	May Spind	
		Patricia A. Paytas - wife	The second secon	Bandit Al Lane St		
or History		20a. Method of Disposition  1 Burial 20 Cremation 3 Removal from S  4 Donation 5 Other (Specify)	20b. Place of Disp cemetery, cri Metropol	position (Name of ematory or other placeMay 4 2 itan Funeral Serv	Date 200 2004 1CE Alex	. Location - City or Town, Stete xandria Virginia
Baltimo	OUC#	21. Signature of Funeral Service Licensee			Rausch Fund Port Repub	eral Home olic Maryland 20676
Physicia	in	23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	used the death. Do not elch line.  RENAL FAILU	. •	ac or respiratory arrest,	Approximate Interval Between Onset and Death
/Medic Examine		Due to (o	r as a consequence of):  RENAL SYND			
8760, cate be executed physician and the burial-transit	Icai Examiner	rif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	r as a consequence of):  PATIC HEPATO r as a consequence of):	MA		
Geath certific death certific attending p	Physician/Medi	in the past 12 months?	nt at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P quires that n signed b	Ď	Part II. Other significant conditions contributing to dea	ith but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2 No 3 Probably 4 @Onknown
II RECORDS, P.O. The law requires that the rate has been signed by the page 2 should be detache.	Completed				24a. Was an autopsy performed 1  Yes 2	
Vital R sicien: The certificate h	Be	25. Was case referred to medical examiner?		Other	eath (Check only one)	
Of Physical distribution	5.	27. Manner of Death 28a. Date of	patrent 2 ER/Outpatie	of 28c. Injury at	Home 5 Residence	
VISION Of VITA Attending Physician: or death. ector: After this certific. by the funeral director,	catio	2 Accident investigation	, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Diagram	Certification:	determined 208. Flace	of Injury - At home, farm, s g, etc. <i>(Specify)</i>	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
To the Hospitel within 24 hours: To the Funeral completely filled	edical	(Check only 2 Medical Examiner: On the base and manner	sis of examination and/or i	ath occurred at the time, date and place investigation, in my opinion, death occurred.	curred at the time, date	and place, and due to the cause(s)
To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	0	29c. License number D40370		Date signed (Month, Day, Year)
10+1		30. Name and address of person who completed cause Peter Wisniewski M.D. Pr	ince Freder		8	
26	State	31. Date filed (Month, Day, Year) 32. Re	gistras Signature	Small a		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 15686 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** ARTHUR MURRY PENNEWELL, JR. 4 4:30 PM 2004 28 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner 7185 Sixty Foot RD Pittsville Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Months 1**X** M 2□ F PA 89 12/4/1914 215-07-3920 Director Usual Residence of Decedent the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County 28e-f show Examiner must be nutified at 1 Tyes 2 No MD **Wicomico Pittsville** Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 7185 Sixty Foot RD 21850 USA Itams 23a death by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 XNo Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Auto Repair 10 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other traumests. 17. Father's Name (First, Middle, Last) Be Arthur Murry Pennewell, Sr. Lucinda Perdue ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 30107 Southhampton Bridge RD Salisbury, MD Connie Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Evergreen Cemetery 5/2/04 Berlin, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of unity Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 2 urbaje 108 William St. Berlin, MD 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. oproximate Interval Between Onset and Death Immediate Cause (Final **Physician** 12resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. pe 2 No 3 Probably 4 Unknown 1 ☐ Yes been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 No 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient Medicai Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n by 4 Homicide pelli Hospital 24 hours a Funeral I 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier .0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0.0. DE. Carrell St.

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

32. Registrar's Signature

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 L = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 Edward James Pumphrey, Jr. May 1, 8:40P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Deeth Examiner Charlotte Hall Veterans Home St. Mary's Charlotte Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex. 1 → M 2 □ F 7. Age (In yrs. last birthday) Days 579-48-7318 7 1Yrs. 10,1932 Washington, DC August Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Directo St. Mary's Maryland Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 26955 Erin Drive 20659 USA Funeral 12. Was Decedent Ever in U.S. Agmed Forces? 1 Å Yes 2 □ No 1951 If Yes, Give Year or Dates: 1955 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrician's Union 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward J. Pumphrey Edith Wilhelmina Blum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12148 Charles Street, La Plata, MD 20646
per of Disposition (Name of Date 20c. Location - City or Suzanne Blocker/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans cemetery 2004, Cheltenham, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signatorye of Funeral Service Licenses Louis 1 Stalo 30195 Three Notch Rd., Charlotte Hall, MD 20622 00 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 🗌 No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ CANCER WITH METASTASES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed ATRIAL FIBRILLATION, HYPERTENSION, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? CORONARY ARTERY DISEASE COLOSTOMY 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar

**Funeral** 

Director

Show

7 is marked other then "natural", or items 23s or traumatic event, the Modical Examiner must be a

permit. Pages 1 and Department of Health Important: If item 27 sny injury or other tr once.

**Physician** 

/Medical

**Examiner** 

attending physician and for use as the burial-transit

signed by the detach

has

certificate

this

After t

Diractor:

within 24 hours a To the Hospital

or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

death with the Maryland

CHVH, CHARLOTTE HALL, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

ULTON 31. Date filed (Month, Day, Year)

			State of Maryland / Department of Health and N  1 - State Registrament   TIPM #25 PER PHY C831 5/17/04 Department of Death		giene 200	4 15688
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physici		ROBERT SYLVESTER PROCTOR	APRTI	Day Yee 2.0 (	M
	/Medio Examir		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of De	
	-Aum		CIVISTA MEDICAL CENTER LAPLATA		CHARI	LES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da)	h 9 F	Birthplece (State or Foreign Country)
	Director		219–16–0911 X 77 Yrs.	OCTOBER :	15,1926 MA	RYLAND
	pus *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show finds for notified at	ō				1 X Yes 2 □ No
2	288-1	ect	MARYLAND PRINCE GEORGES FORT WASHINGTON  10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
18	with a	ā	6801 BOCK ROAD, APT. #104 20744		UNITED ST	1
73	ier death w Items 23s	Funeral Director		ecify Yes or No-		nerican Indian,
3 "	after o	臣	Armed Forces? If Yes, specify Cuban, Mexican, Pueric	Rican, etc.)	Black, W	
93	hours after tural', or its	by	3 ☐ Widowed 4 ☐ Divorced		Specify:	BLACK
73	72 hours "natural",	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	tina	16b. Kind of Busines	ss/Industry
3 2	within ene. then "	nple	Flementary/Secondary (0.12) College (1.4or 5.) life. DO NOT use retired)	9		
32	filed within Hygiene. other then	S	8TH GRADE POSTAL WORKER			GOVERNMENT
Maryland	s I and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hyglene. I health and Mental Hyglene. I he marked other than "natural", or Items 23a or 28a-f show other traumatic event, II a Medical Evantane must be notified at	To Be	17. Father's Name (First, Middle, Last)  CLINTON SYLVESTER PROCTOR  MARGARET.		Maiden Sumame) PROCTOR	
ary	2 should be and Mental is marked (	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rut			, Zip Code)
	and 2 saith a n 27 is		MARIE C. PROCTOR / WIFE 12815 FOREST PARK DRIVE	E. WALDO	RF. MARYL	AND 20601
altimore,	ss 1 and 20 Health item 27		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City	
Ĕ	Page nent o int: If iry or		1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Other (Specify)  1 ☐ WARYLAND VEIERANS CEMETERY APRIL	29, 2004	CHELTENH	AM. MARYLAND
a =	permit. Pages Department of h Important: If ite any injury or of		21 Sign - re of Funeral Service in See A 22 Name and Address of Facility			
ω_	89 5 8		LYDIA C. THURNION JOHNSON MOOS83  THORNION FINERAL HOME, 1 3439 LIVINGSION KOAD, 1	NULAN HEA	D, MARYLAND	20640
8			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	GARS	3	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence on:	100		0
	Examiner	١.	Sequentially list conditions.  b. VEWTVALLIJON HARVY N	ITA a	me Arer	かんしゃ しょう
	p ii	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			1 1/2
	execute in and ial-tran	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):			x MIGT
8760,	S Cia		Sub to (or as a consequence or).			
87		dical	d			
9 ×	eath certifi attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of d	lainea
Вох	eath atter	clar	23b. Was decedent pregnant in the past 12 months?  1		Month	Day Year
0	that the death ed by the atte detached for	lys	1 Yes 2 No 9 Unknown 9 Unknown			
10	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
de sp	w requires been sign should be	d b		1 🗆 Y	es 2 No 3	Probably 4 Unknown
## Records,	w requ	Completed		24a. Was a	an 24b. Were	autopsy findings available
	The far te has age 2	E O		autop: perfor	sy prior to med? death?	completion of cause of
ital	sician: The lav certificate has rector, page 2	0	25. Was case referred to medical 26. Place of Deat			ss 2 No
22	Physical this can	To B	examiner?  1 Yes 2 No Cther: 4 Nursing Ho			pecify)
200	ding Phys		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	
<u>io</u>	Attending r death. sctor: After by the fune	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Divisio	or Attu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
0	ital o					
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Lirector: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  1 Medical Examiner: On the basis of examination and/or myestigation, in my opinion, death occurred and manner stated.	and due to the o red at the time, o	ause(s) and manner a late and place, and di	as stated. ue to the cause(s)
	Mithin 2 To the	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Moi	nth, Day, Year)
	C>F0		D-20629		1112-	1/04
,	•		30. Name an address of perion who completed cause of death (Item 23a), year Print		-110	1
i,	B291		GEORGE H. WATHEN MD 11345 PEMBROOKE SQ. SUIT	F 103 1	INT DODE	MD 20602
	Sta	ate	31. Date filed (Month, Day, Year) 32. Augistrar's Signature	H 103	WALDUKT,	-HD 70003
	Registr	rar	APR 2 7 2004 Marie & April 1			

DHMH 17 Rev 1/2001

A.	QUINN	V	For State Registrar	State o	f Maryla	nd / Depa <i>Ce</i> a	artment of F rtificate of	lealth and Death	Mental Hy	giene Beg No 2	004	15689
	Physici	an	1. Decedent's Name (First, Middle						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	JOHN A.  4a. Facility Name (If not institution		nber)		4b. City. Town, o	r Location of Dea	APRIL	30 ,	2004 unty of Death	1557 P <sup>M</sup>
	LAGITIII	161	PENINSULA REGI			NTER	SALISE				COMICO	
	uneral irector		5. Social Security Number 218-74-7027	6. Sex 1 <b>X</b> IM 2 □ F	7. Age (In yrs 37	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1966	9. Birthp MARY	lece (State or Foreign LAND
land	MO MI		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation		-		11	0d. Inside City Limits
e Mary	da j-ali	ctor	DELAWARE SUSS	EX	(	OCEAN V	'IEW					Yes 2□No
th with th	23a or 28 uni be no	al Director	10e. Street and Number 14 WOODS CIRCLE				10f. Zip Code 1997	0		•	of What Coun	try?
at y failed 4 14 13-0000 should be filed within 72 hours after death with the Maryland	or other treumatic event, the Madical Examinar must be rediffed at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1  Yes If Yes, Giv Year or Da	rces? 2[ <b>X</b> No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Americ Black, White, e ecify: W	
n 72 h	"natu ediçal	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind o	of Business/Ind	lustry
d within	than the M	ф	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	CTIONAL (	•		STATE	PRISO	N
be file	d other	Be	17. Father's Name (First, Middle, I	Last)					me (First, Middle,	Maiden Sun	name)	
should	Is marked other than eumatic event, the Ma	은	JOHN A. QUINN  19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street		UELINE M			Code)
1 and 2	n 27 ls er treu		ANITA CHRISTIN	E QUINN/ 1	WIFE	14 WO	ODS CIRCI					
SS +	If item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from 5	State MET	Place of Dispo	sition (Name of matory or other place CAPE	(e)	Date		on - City or To	
nit. Pa	Important: If any injury or once.	. ,	' 4 □ Donation 5 □ Other (Sp. 21. Sign ture of Funer I Service)	-6	HEN	ILOPEN	CREMATORY	5-1-			ORD, DI	ELAWARE
	any in	1	1 6436	Molso	/	WE WE	LSON FUNI ST AVENUI	ERAL SERV E, OCEAN	VICES,LTI VIEW, D	). ELAWAR	E. 1997	70
/M Exa	sician ledical aminer	ner	23a. Part1. Enter the disease or shock, or heart failure? List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (	a. Mu Due to (i b. Dick	utip/t	quence of: melli	ries con	g, such as cardiac	c or respiratory ar	yng/y	Cemia	Approximate Interval Between Onset and Death
ificate be executed	physicien and is the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (d	or as a consec	quence of):						
The law requires that the death certi	by the attending tached for use a	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Feta antattime of d	al death 3	Ectopic pregnancy Other (specify)				Date of deliver Month	y Day Year
quires that	been signed t should be det	by P	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	~/		e cause of death?
	has je 2	Completed							24a. Was a autop perfor	sy		sy findings available pletion of cause of
alcian	this certificate al director, pag	o Be	25. Was case referred to medical examiner?  1XXY'es 2 □ No	Hospital:	enationt 2 🔽	ER/Outpatient	Othe		ith <i>(Check only or</i> Iome 5 ☐ Resid	100	Other (Case 6)	
l or Attending Physician: after death.	ctor: Alter	Certification; T	27. Manner of Death  1 Natural 5 Pending investig.  3 Suicide 6 Could n determin	28a. Date o (Month) ation 4/30/0 28e. Place	f Injury n, Day Year) O Y	28b. Time of Injury 14:25	28c. Injury Work  M 1 1	at	28d. Describe h  Y// VY C  28f. Location (S  City or Tow	ow injury occ Velicite treet and Num n, State)	curred  2 struct  mber or Rural  6 +4 str	confice while
e Hospite	To the Funeral Direcompletely filted in by	edical C	29a. Certifier (Check only one)  Certifying  Medical 8	Physician: To the xaminer: On the ba	sis of examina	wledge, death	occurred at the tim	e, date and place pinion, death occu	philauleph, , and due to the c rred at the time, d	ause(s) and	manner as sta	ted
To th	To th comp	Me	29b. Signature and title of certifier	1 100	Q.		29c. License O.C.		2	9d. Date sig	1, 200	
J.H	.10		30. Name and address of person w				orint)	Baltimo	ore, Mary	land 2	21201	
	Sta Registra	. 9	31. Date filed (Month, Day, Year)			ture			_			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene o

Physici /Medi	ion	1. Decedent's Name (First, Middle, Le Charles Frankli	st)	0.1414T 7			2. Date of Deal Month	eg. No.	V	3. Time of Deat
				erry			April 0		Year 4	2:10 pm
Examir 	ner	4a. Facility Name (If not institution, giv 604 East E. Stre				4b. City, Town, or L Brunswic		40. Count	y of Death lerick	
<sub>o</sub> Funeral Director			4ZIM 2□E	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 9	Year) 1919	9. Birthp Coun Virg	ace (State or Fore try) inia
M #		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					Od. Inside City Lim
a-f sh	to	MD Frederi	ck	Brunswic						1⊠Yes 2□
3a or 28 st be no	al Dire	10e. Street and Number 604 East E. Stree	t		10f. Zip Code	716	1	0g. Citizen of USA		try?
one. than "netural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates: 1942-1945	1	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rad	ce - America ck, White, a	etc.
Department of Health and Mental Hygiene. important: if item 27 is marked other than "netur any injury or other traumatic event, the Medical once.	Completed by	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12) 1 2	lucation	16a. Deced (Give i life., D		ation during most of work a)	ring	16b. Kind of B		ustry
Hygie other	Be Co	17. Father's Name (First, Middle, Last)		Sel	f-Employ	ea 18. Mother's Nam	e (First, Middle, N	Loge faiden Suman		
Menta	ToB	John H. Quesenber	ry				lie Stev		Í	
27 is ma	i a	19a. Informant's Name/Relationship (7) Phyllis J. Lowe-D		19b. Mailin 60	g Address <i>(Str</i> eet 4 East E	end Number or Rur • Street,	al Route Number, Brunswi	City or Town, ck, MD	State, Zip 2171	Code)
nent of He nt: if item ry or othe		20a. Method of Disposition  1		20b. Place of Dispos cemetery, crem Fairview		ce) V	Date 2	Poc. Location -		
Departri importa any inju once.		21. Signature of Funeral Service Liven		22 M 31	Name and Address elvin T.	ss of Facility Strider rfax Blvd	Co., Inc.			
ysician Medical aminer		23a. Park. Enter the disease, or company of the com	Con	gestive	e Hea	,	ilure		r	onset and Death
ransit	edical Examiner	Sequentially list conditions	b. Athe	ero scler	2120					years
cian ar ourial-t	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events	CO	PD						years
physi s the l	⋝	that initiated events resulting in death) Last		ue to (or as a consequ						years
ding se a	₫	_		$\sim$			11102			
attending d for use a	icia	Part II Other significant conditions on						OCCO HOS COR	itribute to t	he cause of dee
ned by the attending s detached for use a	y Physician/	Part II. Othar significant conditions co	ntributing to death but	not resulting in the und	derlying cause give	en in Part I.	23b. Did tob	_		
s been signed by the attending should be detached for use a	2	Part II. Othar significant conditions co	ntributing to death but	not resulting in the und	derlying cause give	en in Part I.		autopsy	3 ☐ Proba	bly 4 Unknown
s been signed by the attending should be detached for use a	2	Part II. Othar significant conditions co	ntributing to death but	not resulting in the und	derlying cause give	on in Part !.	1 ☐ Yas	autopsy	3 Proba	bly 4 Unknown
entificate has been signed by the attending sctor, page 2 should be detached for use	Be Completed by	25. Was case referred to medical examiner?	Hospital:			26. Place of Death	1 ☐ Yas  24a. Was an performe  1 ☐ Yes  (Check only one,	autopsy ed?	3 Proba	e autopsy finding able prior to oletion of cause ath?
his certificate has been signed by the attending al director, page 2 should be detached for use s	To Be Completed by	25. Was case referred to medical examiner?	Hospital: 1 □ Inpatien	t 2 ER/Outpetient	3□ DOA Othe	26. Place of Death	1 ☐ Yas  24a. Was an performe  1 ☐ Yes  (Check only one) ne 5 ☑ Residen	autopsy ed? 2 √No	3 Proba  24b. Werr avail com of de	e autopsy finding able prior to oletion of cause ath?
his cartificate has been signed by the attending al director, page 2 should be detached for use	To Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital:	t 2 ER/Outpetient	3□ DOA Othe	26. Place of Death	1 ☐ Yas  24a. Was an performe  1 ☐ Yes  (Check only one,	autopsy ed? 2 √No	3 Proba  24b. Werr avail com of de	e autopsy finding able prior to oletion of cause ath?
iner deam. Niector: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use s	To Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 □ No 27. Manyler of Death 1 □ Natural 5 □ Pending	Hospital: 1 □ Inpatien:  28e. Date of Injury (Month, Day	t 2 ER/Outpetient 28b. Time of Injury y - At home, farm, stree	3 DOA Othe 28c. Injury Work M 1 Y	26. Place of Death IT: 4 □ Nursing Hor at ? 'es 2 □ No	1 ☐ Yas  24a. Was an performe  1 ☐ Yes  (Check only one) ne 5 ☑ Residen	autopsy ed?  2 No  ce 6 Other injury occurred and Number	3 ☐ Proba  24b. Werr avail com, of de  1 ☐ 3  or (Specify) ed	bly 4 ☐ Unknown and Unknown a
ifier death. Director: Affer this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Certification: To Be Completed by	25. Was case referred to medical examiner?  1	Hospital: 1 □ Inpatien  28e. Date of Injury (Month, Day  28e. Place of Injur building, etc.	t 2 ER/Outpetient  Year) 28b. Time of Injury  y - At home, farm, stree (Specify)  my knowledge, death c xamination and/or inve	3 DOA Othe  28c. Injury Work M 1 Yet, factory, office	26. Place of Death IT: 4 □ Nursing Hor at ? Yes 2 □ No	1 ☐ Yas  24a. Was an performed to the control of t	autopsy ed?  2 No  ce 6 Other injury occurrence and Number State)	3 Proba  24b. Werravail avail com of de  1 1  or (Specify) ad	bly 4 Unknown authors to let ion of cause ath?  Yes 2 No
in 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending pletely filled in by the funeral director, page 2 should be detached for use	ledical Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manyfer of Death 1  Accident investigation 3  Suicide 4  Homicide	Hospital: 1 □ Inpatien  28e. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  sician: To the best of ner: On the basis of e	t 2 ER/Outpetient  Year) 28b. Time of Injury  y - At home, farm, stree (Specify)  my knowledge, death c xamination and/or inve	3 DOA Othe  28c. Injury Work M 1 Yet, factory, office	26. Place of Death  if: 4 □ Nursing Hor  at ?  fes 2 □ No  2  e, date and place, a inion, death occurre	1 ☐ Yas  24a. Was an performed to the caude at the time, date	autopsy ed?  2 No  ce 6 Other injury occurrence and Number State)	3 Proba  24b. Werravail avail com of de  1 1  or (Specify) ad  ar or Rural R  more as state and due to the	e autopsy finding able prior to oletion of cause ath?  Yes 2 No

**Physician** 

/Medical

Funeral Director

Be Completed by

once

Examiner

Completed by Physician/Medical

Examiner

**Funeral** 

Director

31. Date filed (Month, Day, Year)

29b. Signature and

For		State of M	arylan	d / Depa	rtment	of Heaith ar	nd Me	ental Hyç	giene	^ ^		
1 - State Registrar				Cert	tificate	of Death		F	Reg. No.	20	04	1560
1. Decedent's Nam	e (First, Middle, Last)							2. Date of Dea Month	ith Day		Year	3. Time of Deat
	KATI	IRYN	s.	ROL	F							3:35p
4a. Facility Name (I	f not institution, give	street and number	)		4b. City, To	wn, or Location of I	Death		4c.	County	of Death	1
	Jursing 8					lin	Нес			rce		
5. Social Security N	1 .	7. A		last birthday) Yrs.	If Under 1 Months		Min.	8. Date of Birtl (Month, Day	r, Year)		9. Birth Cou	place (State or For intry)
216-10-3 Usual Residence of			92					10-2	9-11			MD
10a. State	10b. County		10c. City	y, Town or Loc	ation							10d. Inside City Lin
MD	Worceste	r	00	cean P	ines							1 <b>⊠</b> Yes 2 □
10e. Street and Nu	mber				10f. Zip C	ode			10g. Citiz	en of W	hat Cou	intry?
44 Fort	Sumter	South			218	311			US	SA		
11. Marital Status		<ol> <li>Was Decedent</li> <li>Armed Forces</li> </ol>	?	.S. 13. W	as Deceder Yes, specify	nt of Hispanic Origin Cuban, Mexican, F	n? (Spec Puerto F	cify Yes or No- Rican, etc.)	1		<ul> <li>American</li> <li>White</li> </ul>	ican Indian, , etc.
1 ☐ Never Marr 3 ☑ Widowed	ied 2 Married	1 Yes 2	No	11	☐ Yes 2	No Specify:				Specify:	T T1	
35 I Widowed	15. Decedent's Edu	Year or Dates:		16a. Decede	nt'e Heunl (	Documation			16h Kin	nd of Bus	Whi	
	city only highest grad	e completed)	- \	(Give k	ind of work O NOT use	done during most o	f workin	g	TOD. KII	id of ous	9111622411	idustry
Elementary/Second 1 2	ondary (0-12)	College (1-4or	5+)		Home	maker			Ow	n H	Iome	9
17. Father's Name	(First, Middle, Last)			'		18. Mother's	Name	(First, Middle.	Maiden :	Sumame	)	
William	Schultz					Hel	en	Jer				
19a. Informant's N	ame/Relationship (Ty	pe, Print)		19b. Mailing	Address (S	Street and Number of	or Aural	Route Numbe	r, City or	Town, S	State, Zij	p Code)
Karen H.	C1agett	Dgt				ımter So	.,	Ocean	Pir	es,	Mc	1., 2181
20a. Method of Dis	position □Cremation 3 □P	emoval from State	1 ^	lace of Disposi emetery, crema	ition (Name atory or othe	of er place)	Da	ite	20c. Loc	ation · C	City or T	own, State
	5 Other (Specify)	emovar nom state		ık Lawı	n Cem	netery	4-3	0-04	Ba1	tim	ore	e, Md.
21. Signature of Fu	ineral/Service Licens	901.		22.	Name and	Address of Facility						
151	ms lll	W				Funera			-	in,	Mc	1.,21811
23a. Part1. Enter t shock, or hea	he disease, or compli in failure. List only or	cations that cause ne cause on each	d the death ine.	h. Do not enter		1		respiratory arr	est,			Approximate Interval Between
Immediate Cause disease or condition	(Final on a	AM	zhei	imers	K	Reneutra	之					Onset and Death
resulting in death)		Due to (or a	a consequ	uence of):								
Sequentially list co			2011 1 1111									
if any, leading to in cause. Enter Under Cause (Disease or	orlying 🚄	Due to (or as	a consequ	uence of):								
that initiated events resulting in death)	sí i i i	Due to (or as	a consecu	uence of):					_		-	_
		200 10 (01 41	a consequ	uence or,								
		l										
IF FEMALE:		3c. If yes, outcome	of pregna	incv						3d. Date	of dollar	001
in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	I death 3 □E	Ectopic preg Other (spec				-	Mont		Day Year
1 ☐ Yes 2 ☐ 9 ☐ Unknown		9☐ Unknown				7/						
Part II. Other signif	ficant conditions cor	tributing to death	out not rest	ulting in the und	derlying cau:	se given in Part I.		23e. Did to	bacco us	e contrib	oute to t	he cause of death?
								1 □ Y	es 2	No 3	B 🔲 Prot	pably 4 Unkno
								24a. Was a	ın	24b. W	ere auto	opsy findings availa
							_	autops perfor	med?	pri	or to co	mpletion of cause
25. Was case refer	red to medical					26 Place of	Dogth	·	2 No	1 [	Yes	2 No
examiner?	/	lospital:	ent 2	ER/Outpatient	3 □ DOA	Other: 4 Nursi		(Check only or e 5 ☐ Reside		Other	/Specil	7/ T 1770
27. Manner of Deat	h	28a. Date of Inj	ury	28b. Time of		Injury at Work?		d. Describe h				у/
1 <del>□ Nat</del> ural 2 ☐ Accident	5 Pending investigation	(Month, Da	iy rear)	Injury	М	1 ☐ Yes 2 ☐ No						
3 🗌 Suicide	6 Could not be determined	28e. Place of In	jury - At ho	ome, farm, stree	et, factory, o	ffice	28			Number	or Aura	al Route Number,
- Inomicide		building, e	ic. (Specif)	"/				City or Town	i, siale)			
4 Homicide  29a. Certifier (Check only	determined	building, e	of my know of examinat	v) wledge, death (	occurred at		olace, an	City or Town	n, State) ause(s) a	and man	ner as s	tated.

filed within 72 hours after death with the Maryland or Itema 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hygiene. International for Items 23a or 28a-1 show Important: If item 7 is marked other then "natural" or Items 23a or 28a-1 show any injury or other traumatic event. It a Marchall Examinational be intillied at Maryland 21215-0036 Baltimore, **Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed **burial-transit** and Division of Vital Records, P.O. Box 68760, the attending physician use as the detached for ed bluods

KATHRYN

filled in by the funeral director, page 2 Medical Certification; To Be 24 hours after death Funeral Director: / completely To the within 2 To the I State Registrar DHMH 17 Rev 1/2001

After

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of death (Item 23a) (Type, Print)

29c. License numbe

2

29d. Date signed (Month; Day, Year)

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State  St			1 72	23a. Part1. Enter the disease, or compli	cations that caused the dea		•				Approximate
Due to (or as a consequence of):    Due to (or as a consequence of):		Diam's to to a		shock, or heart failure. List only or	e cause on each line.	06	11241	Fall .	10-		
Subjection of the state of the	}			disease or condition	Due to (or as a conse	nuence of):	NAC 9	1716	IRE-		HOURS
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Due to (or as a consequence of):    Due to (or as a consequence of):			ner	if any, leading to immediate	Due o (or as a consec	quence of):	7 111	710 (1)			17/12
The part of the pa		ransi	aml	that initiated events							
Section   Sect	Š	e exe sian a urial-		resulting in death) Last	Due to (or as a consec	quence of):					
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1   Yes   2   No   3   Probably   4   Unknown	j.	the d y the iched	ysic								
performed death   1   26. Place of Death (Check only one)   25. Nas as refer   medical   examiner?   1   Yes   2   No   27. Manner of eath   1   Yes   2   No   28. Injury at	T.	that ned b deta	y Pł	Part II. Other significent conditions con	tributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	icco use contrib	ute to the cause of death?
performed death   1   26. Place of Death (Check only one)   25. Nas as refer   medical   examiner?   1   Yes   2   No   27. Manner of eath   1   Yes   2   No   28. Injury at	2	quire; n sig		ACUTE UPPER	2 61 86	EED			1 ☐ Yes	2 No 3	☐ Probably 4 ☐ Unknown
State   Stat	3	s bee	olet	DARFIES ME	11:17115					24b. We	re autopsy findings available
25. Mas as a refer of medical examiner?	Ĕ	The la	mo	CAPAIAMA	= COLAN				performe	ed/? dea	ath?
27. Manner of eath   Setting   Setti	<u> </u>	ian: rtifica ctor, p	ø		COUNT			26. Place of Dea			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30b. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  28f. Location (Street and Number or Rural Route Number, of City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602	<u> </u>	hysic his ce I direc	0		1 Supatient 2L	ER/Outpatier	IL 3LI DOA	4   Nursing n	ome 5□ Residen	ce 6 □Other	(Specify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30b. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  28f. Location (Street and Number or Rural Route Number, of City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602	<u> </u>	ng P	ou:		28a. Mete of Injury (Month, Day Yeer)				28d. Describe how	injury occurred	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  31. Date filled (Month, Day, Year)  32. Signature	<u>S</u>	tandi leath. tor: A the fu	catl	Accident investigation				Yes 2 □ No	00( 1 (0)		
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  31. Date filled (Month, Day, Year)  32. Signature	<u> </u>	or At	rtifi	determined	building, etc. (Speci	iome, tarm, str fy)	eet, factory, office		City or Town,	et and Number State)	or Hural Houte Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  31. Date filled (Month, Day, Year)  32. Signature	!	pitel		29a Certifier 1 Certifying Phys	sicien: To the best of my kn	owledge deat	n occurred at the tin	ne date and place	and due to the cau	use(s) and many	ner as stated
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  31. Date filed (Month, Day, Year)  32. Signature		a Hos 24 h a Fun etely	dica	(Check only 2 Medical Exemin	<b>ter:</b> On the basis of examina	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time, dat	e and place, and	d due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  31. Date filed (Month, Pay, Year) 2004  32. Signature		To th within Fo th	Me	29b. Signature and title of certifier	1 2 1 2		29c. License	e number	290	d. Date signed (	Month, Day, Year)
Louis Koffman, M.D. 12070 Old Line Center, Waldorf, Maryland 20602  State  31. Date filed (Month Pay, Year) 2004  32. Signature				<b>)</b>	AHA		0/2	GAL		5/4	109
State 31. Date filed (Month, Cay, Year) 32. Fegistrar's Signature	,			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	(00			
State 31. Date filed (Month, Cay, Year) 2004 32. Signature	1	135			12070 01d	Line Co	enter, Wa	ldorf, Ma	aryland :	20602	
				31. Date filed (Month, Day, Year) 20	04 32. Segistrar's Sign	ature	beck				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAY 4 2004 3:00 A M CHESTER THOMAS RISON /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST MARY'S CHARLOTTE VETERANS HOME CHARLOTTE HALL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)

DEC 21 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 577-20-6035 Director 84 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes X☐ No Maryland | St Mary's Charlotte Hall Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 29449 Charlotte Hall Road 20622 or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by Specify: White 3 Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 then College (1-4or 5+) Supervisor US Government Pages 1 and 2 should be filed in ment of Health and Mental Hygic ant: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Mattie Bowie Rison William Rison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Rison (son) 9860 Poorhouse Road Port Tobacco, MD 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages of Pepartment of Pepartment: If ite any injury or ot once. 1 ☑Burial, 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donalon 5 ☐ Other (Specify) Maryland Vets Cem 5-7-04 Cheltenham, MD 21. Signature of Fyreral Service License 22. Name and Address of Facility Eberwein Funeral Services M00173 M Wern 4433 White Pls. La. White Pls., MD 20695 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** aidia arrest hunc /Medical resulting in death) Due to (or as a consequence of): Examiner hisbertlesseal E-quertian, list our afturis, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (o a consequence of): Examiner The law requires that the death certificate be executed and resulting in death) Last attending physician are for use as the buriat-Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year P.O. 1 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 ZUnknown as been si 2 should 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha autopsy performed' 2 🗆 No 1 ☐ Yes 2 ☑ No or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Natural 5 Pending death. 1 ☐ Yes 2 ☐ No thours after death.

Cunaral Diractor: A

Sly filled in by the fu investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours al To the Funeral D completely filled i Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0-005694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARAKE(4 i BAIQ K. i) 6620 CRAIN HWY STE-102 LAPLATA 20646 7.D. 31. Date filed (Month, Day, Year)
MAY 0 5 32. gistrar's Signature State 2004 Registrar

			1 For Amend	State of Maryland Items 8,9 per				ntal Hygier	ne 2001	. 15601
			Registrar  1. Decedent's Name (First, Middle, Last,		Cei	illicate of		Reg. I	٧٥. ٢ ٠ ٠ ١	3. Time of Death
	Physici	an			1,-				) 2004	11:10 A
	/Medic		Thomas G.  4a. Facility Name (If not institution, give		K	4b. City, Town, o	r Location of Death		4c. County of Deel	
	Examin	e	Layhill Genesis	_		Silve	er Spring		Montgo	merv
	Funeral Director		5. Social Security Number 6. Security Number 133		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea	9. Birt	hplece (State or Foreign buntry) California
	and w		Usuel Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mary	ō	MD Montg	omery Si	1 war	Spring				1 ☐ Yes 2 ☐ No
	death with the Maryland rms 23e or 28a-f ehow	Director	10e. Street and Number	omery br	1161	10f. Zip Code		10g. (	Citizen of What Co	untry?
	h with		3227 Bel Pre R	oad		2	20906		U.S.A	
	ems cms	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of H	dispanic Origin? (Specifian, Mexican, Puerto Ric	y Yes or No-	14. Race - Ame Black, Whit	ricen Indian,
92	ours after death with the Marylan rel', or Nems 23e or 28e-f ehow Evant or must be notified a	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 21 No		,		hite
5-003	72 hours after neturel', or Ite	d b	3 Widowed 4 Divorced	Year or Dates:	16a Daga	death Heyel Occur	ation	105	, ,,	
5	"net	iete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	du <i>ring</i> most of <i>working</i> d)	160.	Kind of Business/	industry
12	be filed within 72 hours tal Hygiene. d other then "netural", event, I'm Medical Exa	Completed	Elementary/Secondary (0-12)	2 Years	_	erment W			Treasu	ry Dept.
0	i Hygie other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name (F			
<u>a</u>	Ald be Alenta rked tic ev	To B	John Stark				Eva Mai	rie Sha	ttuck	
Maryland 2	od 2 shoulth and N		19a. Informant's Name/Relationship (T) Stuart Elkman (	,			and Number or Aural F			Zip Code) MD 20906
ē,	Healt Healt Hem 2		20a. Method of Disposition	1 00	ace of Dispo	osition (Name of matory or other place	Date	9 20c.	Location - City or	Town, State
Baltimore,	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 4 ☑ Donation 5 ☐ Other (Specify)	demoval from State	-		001 4/21	/2004 W	ashingt	on, DC
a	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Ligens		22	2. Name and Addre	ss of Facility Aus	tin Roy	ster Fu	neral Home
m	8 5 E 8		1 R		3	8821 14t	h ST, N.V	V. WDC	20011	
8	Physician		23a. Part 1. Enter the disease, or compleshock, or head failure. List only of Immediate Caus. (Final							Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ience of):	-	1110110			carys.
	Examiner		Cognostially list conditions	Corona	- the	arun	1 dise	ase		485.
	D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	ence(df):			0.150	4'6	1156
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687	ficate physis the	edic		1.		<u></u>				
). Box	The law requires that the death certificate ite has been signed by the attending physoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of del Month	very Day Year
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ds,	iires tha signed d be det	d by	arm one organization			nashjing sauss gir	311117 4111			obably 4 @t/nknown
Ö	w require been si	Completed						240 Mina on	24h Ware au	tanau findana avadabla
Rec	has has	m m						24a. Was an autopsy performed?	prior to d	topsy findings available completion of cause of
a			OF Man case referred to medical					1 Yes 2		20 No
<del>=</del>	Physicien: The this certificate h al director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	EB/Outpatier	nt 3 DOA Oth	26. Place of Death (Coer: 4 Nursing Home		6 DOther (Coa	24.1
ō	Attending Physician: is death. ector: After this certifici by the funeral director, i	⊢	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	y at 280	d. Describe how in		aiy)
<u>0</u>	nding l ath. r: After e funer	atio	1-Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 🗆	Yes 2 □No			
Division of Vital Records,	of Attendation after deati	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, str	reet, factory, office	28f	Location (Street City or Town, Sta		rai Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier Certifying Phy (Check only one)	sicien: To the best of my know ner: On the basis of examinati and manner stated.	wledge, deatl ion and/or in	h occurred at the tir vestigation, in my o	me, date and place, and pinion, death occurred	I due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29d. E	ate signed (Month	n, Day, Year)
	, , , , , , ,		X.NO	maz-		D50	987.	4	-23-	54.
			30. Name and address of person who co	ompleted cause of death (Item			1			
_			AHMED NAWAZ			railher:	sburg m	10 208	383.	
- k	Sta		31. Date filed (Month, D. Ader)	32. Register's Signat	ure	Contra de	4			

unpend item#23a,27,Per ME,C831,5/18/Oveg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gary William Spies 04-03171 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 May 10, Gary William Spies 0227 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4847 Philadelphia Road Aberdeen Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 5, 1956 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 215-68-0383 Yrs. Director 48 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Exeminer must be politized at 1 ☐Yes 2 XNo Director Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 U.S.A. 4847 Old Philadelphia Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11, Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other then "neturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic/Carpenter 0 County Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Violet Stanley William J. Spies 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Spies (Son) 343 Woodland Green Ct., Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gdns. 5/14/04 Bel Air, MD 21. Signature of Euneral Service Licensee Tarring—Cargo Funeral Home, P.A. 21001-3399 Aberdeen, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or as a consequence of) The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown à s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No page 2 certificate 1 Yes 2 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home SEResidence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1X Yes 2 No 5 After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1XXNatural Injury 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 \ Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KILL O.C.M.E. May 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUBIO, 17

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

Esses & francis

32. Registrar's Signature

			For State Registrar	State of M	larylan	•	artmen rtificat						2001	15696
	Physici		1. Decedent's Name (First, Middle, Las Marjorie Fra:		eibe	 el					2. Date of Dea		2004	3. Time of Death  12:32 p <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give	street and number				Town, or	Location o	of Death	-	1	County of Dea	th
	Funeral Director	0	Solomons Nursing 5. Social Security Number 220-38-4601		ge (In yrs. 90	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Aug 8,	Year)	9. Bir	thplace (State or Foreign ountry)
	the Maryland 28e-f show	ector	Usual Residence of Decedent  10a. State 10b. County  MD Calver  10e. Street and Number	rt	10c. Cit	y, Town or Lo Huntir						10a. Citi	zen of Whai C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
٥	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show acted Examiner mast be notified at	Funeral Director	830 Carson Road  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2∑ If Yes, Give	?	i		lent of Hi	2063 spanic Ori n, Mexican Specify:		ecify Yes or No- Rican, etc.)		USA 14. Race - Ame Black, Whi	erican Indian, te, etc.
215-0036	filed within 72 hours Hygiene. Wher than "natural", out, the Medical Exp	Completed by	3 XWidowed 4 ☐ Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)	Year or Dates:	5+)	16a. Decec		i Occupa	ition Jurina mosi	t of worki	ng	16b. Kir	WI nd of Business	nite Undustry
Maryland 21	ad be	To Be Con	17. Father's Name (First, Middle, Last) Sherman Wodell		er	home	emake:	r	18. Mothe		(First, Middle,		n home Sumame)	Kaiser
	nd 2 shoulth and M	0.000	19a. Informant's Name/Relationship (1) Richard F. West,	Гуре, Print) SON		830	Carso	on Ro		Hunt	I Route Numbe	, MD	20639	9
Baltimore,	Pages 1 ment of H ant; If Itel ury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	1)	, ,	Place of Dispo cemetery, cren iphany	natory or o	ther place tery	0	5-03	-04		cation · City or	
ga	permit. Departi Import. any Inj.	(i -	21. Signature of Funeral Service Licen  23a. Part1. Enter the disease, or comp	K. Tho	d the deat	F	Rauscl	n Fui	neral	Hom	e, P.A.		ings, N	Approximate
8/60,	ate be executed /Medical Examiner /Medical Examiner / this burial-transit	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a)	ine.  ke s a conseq  F s a conseq	uence of):								Inierval Between Onset and Death
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cords, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions of	ontributing to death I	but not res	ulting in the ur	nderlying c	ause give	en in Part I.			bacco u	_	the cause of death?
T O	The law ate has b page 2 st	Completed									24a. Was a autop perfor 1 Yes	med?	24b. Were au prior to death?	utopsy findings available completion of cause of
N (a	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1  Inpali	ient 2 🗆	ER/Outpatien	it 3 DO	Othe			(Check only or ne 5 ☐ Resid		Other (See	ciful
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DIVISION	그 부 는 ㅁ	Certification:	3 Suicide 6 Could not be determined	building, e	tc. (Specif	y)					City or Tow	n, State)		ural Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical		ysician: To the best niner: On the basis of and manner st	of examina									
	To th within To th comp	Me	29b. Signature and title of certifier	Tando 1	up			License			1		signed (Mont	
	4		30. Name and address of person who of David J. Tardio,  31. Date filed (Month, Day, Year)	M.D., 1	10 Ho	spital	Rd.,		310,	Pri	nce Fre	deri	ick, MD	20678
	Sta Registr		MAV A	3 2004 A	40 agria	. K	dos	all I						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 1818 JOAN DIANE SHORES /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2X F Yrs. 58 10/3/1945 OH 295-48-5454 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County s 23a or 28e-f shortest at Ocean Pines 1 Yes 2 □ No MD Worcester Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21811 1 Falconbridge RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner n Black, White, etc filed within 72 hours after 1 Never Married 2 Married ō Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F Sarah Rosepapa David Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 Falconbridge RD Ocean Pines, MD Ronald Shores 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of the Pines | 5/1/04 Ocean Pines, MD permit. Pag Department Important: f any injury o \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Junyal Service License 108 William St. Berlin, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician wa CNE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to fr as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 164/4000 ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ys ひoひサ/シal Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No 4/و/م/ عم⊙ Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 EInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 03 Registrar 2004

SHORES

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			Registrar			Cel	tificate	OT DE	eatn	—-т	2. Date of Deat		104	3. Time of	) 9 8
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lan	should be filed within 72 hours after death with the Marylan of Mental Hygiene. Trarked other than "natural", or flems 23a or 28a-f show marked other than "natural", or flems 23a or 28a-f show maric event, the Medical Ever Last must be notified at	To B	Robert Otto	Schell	in			Ī	Annie	e	Virgir	nia	Mile	es	
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Box (	certif nding use a	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75 at a m i a m a m					23d. D	ate of deliv	•	
-	death e atte id for	icia	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			⊒Ectopic pre ⊒ Other (spe					N	lonth	Day Y	Year
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alF	n: The			wleast	シナリ						1 ☐ Yes	2 TNo	1 🗆 Yes	2□ No	
Σ	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Dinpati	ent 2	ER/Outpatie	nt 3 DOA	Other			n <i>Check onl∈on</i> me 5 ☐ Reside	-	ther (Specia	(v)	
	ding Physician: The lav h. After this certificate has funeral director, page 2	n: To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time o		3c. Injury a Work?	-	-	28d. Describe ho				
ion	nding ath. r: Afte	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		y / oui/	mary	М		s 2 🗆 i	Vo _					
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, e	jury - At h tc. (Specia	ome, farm, st	reet, factory,	, office			28f. Location (St City or Town		nber or Run	al Route Num	ber,
	urs aft			ysicien: To the best			Nh	at the time	data an	d plane	and due to the e	auso(s) and n	222225	rtated	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medicel Exem one)	ysicien: To the best niner: On the basis of and manner si	of examina	ation and/or in	n occurred a	in my opir	nion, deal	th occuri	ed at the time, d	ate and place	, and due t	o the cause(s	)
	o the	Me	29b. Signature and title of certifier				29c.	License r	number	Ma	ryland 2	9d. Date sign	· i		
	- >- 0		> UM, h	ospitalis	ti	~0	0	60	39	0		4/2	8/0	4	
			30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type	, Print)	ľ	5.	7	f	M		70	
IC	)+1		Adees Jaber 1 31. Date filed (Month, Day, Year)	1. D - //	D Ho	Sp. Kd	STE	DID,	TRIKE	TRE	WELLER	(III)	206	10	
	St Regist	ate rar	MAY 0	completed cause of 32. Regist 3 2004	Been	es St.	Spa	els.							
							- A								

			For	partment of Health and Mental ertificate of Death	Hygiene Reg. No. 2004 15690
			Decedent's Name (First, Middle, Last)		of Death 3. Time of Death
	Physicia /Medic		JOHN A. SOLES	ape	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Lorien Nursing Home	Columbia  VI If Under 1 Year   If Under 24 Hrs.   8, Date	Howard of Birth 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 123 3 4 1737 6. Sex 80 Yrs.	Months Days Hours Min. (Mon	th, Day, Year) -30-1923 West Virginia
			Usual Residence of Decedent		
	arytan show		10a. State 10b. County 10c. City, Town or		10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-1	ecto	MD Howard Elli	cott City 10f. Zip Code	10g. Citizen of What Country?
	with ta or 3	Funeral Director	3516 MacCubin Valley Trail	21042	United States
	ns 23	era		B. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	
9	after or Ite		1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ No If Yes 2 □ No	1 ☐ Yes 2 ★No Specify:	Specify:
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. id other than "netural", or ttems 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		White
15-	n 72 l	Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	Howard County
12	within jene.	mo	Elementary/Secondary (0-12)  College (1-4or 5+)  5+  Edu	icator	Public Schools
פָּ	be filed tal Hygie d other event, the	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
ylar	hould be d Menta marked matic ev	2	Peter Ross Soles		beth Dale Frum
Maryland	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic				Number, City or Town, State, Zip Code) 21042 rail Ellicott City MD
a)	s 1 and if Healtl item 27 other 1		20a Method of Disposition 20b. Place of Dis	position (Name of Date	20c. Location - City or Town, State
nor	ages ant of it: If it y or o		1 \( \mathbb{R}\) Burial 2 \( \text{Cremation 3 \( \text{Pemoval from State} \) Crest	Lawn 5-5-200	4 Marriottsville, MD
Baltimore,	permit. Pages Department of h Importent: If ite any injury or of			22. Name and Address of Facility Harry	H. Witzke's Family FH
Ö	Depar Impo any ir		Jam Collins-Withte	112 Old Columbia P	ike Ellicott City, MD
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		ttory arrest, Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	, Alzheimer's	2 years
Н	/Medical Examiner		Due to (or as a consequence of):		
		er	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):		
	cuted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c		
, 00	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):		
68760	death certificate be executed e attending physician and of for use as the burial-transit	dical	d		
9 X	leath certifica attending ph I for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Вох	atten d for u	cian	23b. Was decedent pregnant   1 Live birth 2 Fetal death 3   1 Ven 2 No.   1 Ven 2 No	B Ectopic pregnancy 5 Other (specify)	Month Day Year
Ö.	t the by th ache	Physician/Med	9 Unknown		
s, p	g g i	by P	Part II. Other significant conditions contributing to death but not resulting in the hoo intra cra wal hemoto m	and any my control great and any and any	Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
ord	v requir been si should	ted	NIO INTIA CIA INDO IL GIRO I OTTO		
Vital Record	25 8	Completed	9		. Was an autopsy performed?   24b. Were autopsy findings available autopsy performed?   24b. Were autopsy findings available auto
al			25. Was case referred to medical	1 □ 26. Place of Death (Check	Yes 2 No 1 Yes 2 No
Σ	Physician: this certificant	o Be	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	04	Residence 6 Other (Specify)
o of	ding Phy h. After thi funeral c	n: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28d. Des	scribe how injury occurred
sior	Attending or death. ector: After by the fune	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
Division	F # F C	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)		ation (Street and Number or Rural Route Number, or Town, State)
	Hospitel 24 hours a Funeral t		29a, Certifier 1X Certifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place, and due	to the cause(s) and manner as stated.
	the Hos nin 24 h the Fur npletely	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
	To the Hospitel c within 24 hours af To the Funeral D completely filled in	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	(1)		MID.	N20221	may 02, 2004
/	17700		30. Name and address of person who completed cause of death (Item 23a) (Type Harry Li, MP. 10780 Hickory)	ry Ridge Rd, roll	e time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  May 02, 2004  LMbix, MD21044
	Sta	ate	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	4 1-10	
	Regist		MAY 0 4 2004 Blow &	Coart )	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** FANNIE ELIZABETH SMITH MAY 5:35P 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES CHARLES COUNTY NURSING & REHABILITATION CENTER LAPLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Month, Day, Year)

NOVEMBER 14, 1905

Simple Section 1905

WINGINIA **Funeral** 1 □ M 2 1 F 98 Director 579-68-2334 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. In Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Director MD CHARLES LAPLATA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? UNITED STATES 10200 LAPLATA ROAD 20646 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: ģ Specify: 3X Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TRENE GAINES ROBERT GUIRICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9120 BOWIE ROAD, NANJEMOY, MARYLAND 20662 ARNETTA DATCHER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MI HOPE CHURCH CEMEITERY MAY 6, 2004 NANJEMOY, MARYLAND 21. Signature of Funeral Service Lice/see 22. Name and Address of Facility any ir THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke 3 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classes of tijer) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 1 ☐ Yes 2 No 2 4 X Nursing Home 5 Residence 6 Other (Specify) 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Diractor: 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Naldorf

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month,

			1 - For State Registrar	State o	f Maryland	/ Depa	artment of H rtificate of	lealth ar <i>Death</i>	nd Mental Hy	/giene2 (	004	15701
	Physici		1. Decedent's Name (First, Middle Nellie Rebe					-	2. Date of D Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution 1155 Adelina Ro		nber)		4b. City, Town, o Prince F		Death	2004 4c. Cour Calv	nty of Death ert	828 P <sup>M</sup>
	Funeral Director		5. Social Security Number 218 38 9464	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. last 93	hirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, D June 1	ay, Year)	9. Birthp Coun Mary	
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County Maryland Calver		10c. City, T	own or Lo	Frederic	:k			1	0d. Inside City Limits 1 ☐ Yes 2X No
	h with the 3e or 28a- st be notif	al Director	10e. Street and Number 1155 Adelina Ro	oad			10f. Zip Code 20678	}		10g. Citizen o United		
9036	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "naturel", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	Armed Fo	2 <b>∑</b> No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Originan, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	B:	ace - Americ lack, White, cifywhite	etc.
Maryland 21215-0036	d within 72 h jiene. r then "netu the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	durina most c	of working	16b. Kind of  OWn h		dustry
land	should be filed vand Mental Hygies marked other tumatic event.	Be	17. Father's Name (First, Middle, I						s Name (First, Middle e Olivia F		ame)	
	and 2 should be ealth and Mental 127 is marked er treumatic ev		19a. Informant's Name/Relationsh Clara Esther Wood— A						or Rural Route Numb Lt MD 20770	er, City or Tow	n, State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other treumatic elem.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place ceme Asbury	e of Dispo etery, crej Cennet	sition (Name of natory or other place CELY	May 7 2	Date 2004	20c. Location Barstow,		
Balt	permit. Departi Import any inj		21. Signature of Funeral Service I	100			. Name and Addre	_	Rausch Fu Port Republio			
学	Physician /Medical Examiner and phisician sthe pnial-transit	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of the sase or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	ONGE or as a consequen	ce of):	UE H	EAR	T FA	ILUR	= =	Approximate Interval Between Onset and Death
O. Box 68760,	death certif e attending od for use a	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live bi	come of pregnancy rth 2 Fetal de- ant at time of death wn	ath 3	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
ords, P.O.	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditio	-43	ath but not resultin	-		en in Part I.	23e. Did	1/	ntribute to the	e cause of death? ably 4 □Unknown
Vital Records,	The ate h	Completed							24a. Was auto perfo	an 24b psy prmed? 215 No	death?	psy findings available inpletion of cause of
Division of Vita	To the Hospital or Attending Physicien: Th within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1	28a. Date of (Montiliation loot be need 28e. Place		Outpation b. Time of Injury , farm, str	28c. Injun Work M 1 🗆	er: 4 □ Nursi ⁄at	28d. Describe	dence 6 00 how injury occu	irred	Houte Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the Examiner: On the ba and mann	sis of examination	dge, death and/or inv	occurred at the tin restigation, in my of	ne, date and pointion, death	place, and due to the occurred at the time,	cause(s) and m date and place	nanner as sta , and due to	ated. the cause(s)
)	Withi To II	M	29b. Signature and title of certifier	Alleran	Physi		29c. License	number	427	29d. Date sign		Day, Year)
	5			hi Pr	nce 1	500		M	2076	78	7	
	Sta Registr		31. Date filed (Month, Day Year)	0 4 2004	gistre's Signature	J.	April 8					

REPLACE MENT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April Ruby **Physician** Carter Woolford 27, 2004 9:00 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Hospice House Easton Talbot If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 2, 1 5. Social Security Number 215-36-1954 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 64 ,1939 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or Items 23s or 28a-f show ury or other treumatic event, the Madical Examinet must be notified at 10d. Inside City Limits MD 1 XYes 2 ☐ No Director Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29753 Penny Lane 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced **Black** Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) worker's union 12 organizer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Kiah Dorothy Carter ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Logan 29753 Penny Lane Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Bethel Cemetery 5/04/04 ⁴ 4 □ Donation 5 □ Other (Specify) Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, PA cenelle 510 Washington St. Cambridge, MD 21613 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician cara resulting in death) /Medical Due to (or as a consequence of): Examiner on Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed been signed by the attending physictan and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 TUnknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 200 1 🗌 Yes 2□ No To the Hospitat or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificd completely filled in by the funeral director, 25. Was case re-rred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ↑ ☐ Inpatient 2 ER/Outpatient 3 DOA Dther: 4 Nursing Home 5 Residence 6 Wher (Specify) Certification; To 1 ☐ Yes 2 🕽 🕽 28a. Date of Injury (Month, Day Year) 27. Manner of Seath 1 (2 Matural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT J. SMOLOSKI, M.D.609B DUTCHMAN'S LANE, EASTON, MD 21601

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

JUN 0 9 2004

registrar  redent's Name (First, Middle, Laster's Name (First, Middle, Laster's Name)  Residence of Decedent  State	ILES  TO Sex  Sex  TO M 2 F  TO Sex  TO M 2 F  TO Sex  TO M 2 F  TO Sex  TO M 2 F  TO Sex  TO Sex  TO Sex  TO Sex  TO Sex  TO Sex  TO Sex  To	Wash 191 20b. Place o constru	## Ab City  ## Ab City  ## Ab City  ## Ab City  ## Ab City  ## Ab City  ## Under  ## Months  ## 10f. Z  20  13. Was Decident's Us  ## Give kind of w  ## DO NOT  ## Chanic  ## 130 Reg  ## Disposition (N. W. creations of the color)  ## City Color of the color of the	y, Town, or Location of D.  A Francisco Control	2. Date of Dear Month Path Hrs. 8. Date of Birt (Month, Da) July 23  P (Specify Yes or Noverto Rican, etc.)  Working  Name (First, Middle, C)  Rural Route Number	Day Year 2 200  4c. County of Deat  4c. County of Deat  4c. County of Deat  4c. County of Deat  9. Bin Co Mar  10g. Citizen of What Co USA  14. Race - Ame Black, Whit Specify: Bl.  16b. Kind of Business Prince Geo  Board of E  Maiden Sumame)  Brown	thplece (State or Fore puntry) yland  10d. Inside City Lim 1 XYes 2 Duntry?  prican Indian, te, etc. ack //industry rges
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	N N	MO1323	1.00	and Address of Facility Funeral Home	e P.A. Acı	uasco.Marvl	and
Part I. Enter the disease, or co shock, or heart failure. List onlediate Cause (Final ase or condition ting in death)  Heritially list conditions, the leading to immediate e. Enter Underlying to (Disease or injury initiated events ting in death) Last	mplications that caused the cause of the cause on each line.  a. Due to (or as a Due to (or a) D	consequence	of):	ode of dying, such as can			Approximate Interval Betwee Onset and Dea
EMALE: Was decedent pregnant in the past 12 months? 1 Uves 2 No 9 Unknown	d	Petal deatl	n 3 ⊟Ectopic 5 ⊟ Other (a			23d. Date of del Month	livery Day Yea
I. Other significant conditions	s contributing to death but	t not resulting	in the underlying	cause given in Part I.		obacco use contribute to	• /
							utopsy findings avai completion of cause 2 No
Vas case referred to medical xaminer?	Hospital:			Other	Death (Check only o		
lanner of Death	28a. Date of Injury	/ 28b.	Time of	JUA 4 Nursin			cify)
Accident investigati	t be 28e. Place of Injur	ry - At home, f	М	1 ☐ Yes 2 No			ural Route Number,
	aminer: On the basis of e	examination a					
			2				. /
(Check only 2 Medicel Ex				RES-000		Aprila	24, 2004
la C	yes 2 No anner of Death Natural 5 Pending Accident 6 Could no Homicide 6 Certifier 1 Certifying (Check only 2 Medicel Ex	Yes 2	Yes 2	Yes 2	Yes 2   No	Yes 2   No	Yes 2   No

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar AMFND TIFM #23a&b PER PHY C831 5/14/94/tipecate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** Marc 200 CHARLOTTE KATHERINE WADE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 2, 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 🖾 F Yrs Director 213-42-2188 81 1922 PENNSYLVANTA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1⊠Yes 2□No Director MARYLAND WASHINGTON BOONSBORO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 141 SOUTH MAIN STREET 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit, Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "n eny injury or other traumatic event, Ite Mad ones. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 LEROY W. EAVEY CORA MAE CREAGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5006 PORTERSTOWN ROAD, KEEDYSVILLE, MARYLAND 21756 BRENDA J. DODSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/30/2004 BOONSBORO, MARYLAND MT. ZION CEMETERY 21. Signature of 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland ert1. Enter the disease, or comcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PSELIDO MEMBRANCUS COLUTUS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) the attending physician a hed for use as the burial-P.O. Box 68760 Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an autopsy performed? Yes 2 No page 2 s has certificate 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 25 No Let In patient 2 ER/Outpatien 4 Nursing Home 5 Residence 6 Olher (Specify) 2 3E DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 🗌 Homicide To the Hospital 29a. Certifier 🖶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signalure and title of certifier 29c. License number (MI) 3/29/04 20233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12931 oakhill AVR, Hagerstown, Md 217x2 PULIVARTI, MD BAPURAO 31. Date filed (Month, Day, Year) MAR 3 0 32. Registrar's Signature State Registrar

				Please	Type or P	rint in Bla	ack In	delible	ink.	Ensure A	All Copies	s Are	Legible.	
			1 - For State Registrar		State of	Maryland	Ce <sub>i</sub>	artmen rtificat	t of He	ealth and Death	Mental Hy	/gien Reg. No	e2004	15705
	Physic	ian	1. Decedent's Name (	First, Middle, La	st)						2. Date of D	eath Da	y Year	3. Time of Death
	/Medi		Marian				Zel				0.5	0		2:30a M
7	Exami	ner	4a. Facility Name (If n	-						Location of Dea	th	40	. County of Deat	
	<u> </u>		5. Social Security Num		cal Cen	ter Age (In yrs. last	t hirthday)	If Under	aPla	ta If Under 24 Hrs	Data of Pi	#b	Charl.	es
100	Funeral Director		577-40-07		_M 2□F	81	Yrs.	Months	Days	Hours Min	. (Month, D			thplace (State Foreign buntry)
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	urylan show	_	10a. State 1	0b. County		10c. City, T	Town or Lo	cation						10d. Inside City Limits
	Ba-f	Sch	MD		rles		La	Plata						1 ☐ Yes 2 No
	with ti	급	10e. Street and Numb					10f. Zip				10g. Ci	tizen of What Co	ountry?
	eath	eral	11. Marital Status	Shanno	n Court		13 1	Was Deced		646	Consitu Van ar N		USA 14. Race - Ame	door ladies
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036	al', o	þ	3X Widowed 4	Divorced	If Yes, Give Year or Date	_		1 ☐ Yes 2	2 XNo	Specify:			Specify: 7	√hite
21215-0036	72 hours after death with the Maryland natural, or Itams 23a or 28a-f show dical Examinal most be notified at	Completed by Funeral Director	(Specify	5. Decedent's Ed	lucation de completed)	1	6a. Dece	dent's Usua	il Occupat	ion iring most of wo	rkina	16b. K	(ind of Business/	Industry
121	within ene. than	mpl	Elementary/Second		College (1-4	or 5+)	life. i	DO NOT us	e retired)		,9			
	filled v Hygie other t	ပိ	O 17. Father's Name (Fil	ret Middle Lasti				Homer			me (First, Middle	Administra		ome
au	ould be filed within Mental Hygiene. arked other thar atic event, the M	o Be	Harry Wi								tte Mc			
Maryland	should I and Meni Is marke	ို	19a, Informant's Nam				19b. Mailir	ng Address	(Street ar				or Town, State, Z	in Code)
	and 2 palth a n 27 ls		Judy Hei	lston/D	aughter	:	1132	24 S1	nann	on Ct.	La Pla	ata,	MD 206	46
Ore	of He		20a. Method of Dispos	sition	Domougl from Ct	20b. Place ceme	e of Dispo etery, cren	sition (Nam	ne of ther place,	)	Date	20c. L	ocation - City or	Town, State
Ē	Pages ment of I ent: If It		`4 □Donation 5			Brin	nsfie	eld-E	Echo	ls 5/1	0/04	Cha	arlotte	Hall,MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Examana, must be millised at once.		21. Signature of Fune	ral Service Licen	500	M00945	l E	XEHZ	RT-	ĔĠĦÖLS	FUNERA	AL F	HOME, P.	Α.
	4		23a, Part1, Enter the	disease, or com	olications that cau	sed the death. [		· U ·	ROX	-56/-L	A PLATA	$\Delta$ MI	2064	6 Approximate
	Observation		23a. Part1. Enter the shock, or heart for Immediate Cause (Fir			h line. ANOXZ			(sp	R. Our	Lk			Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	-	a	as a consequen		610			2			
	Examiner				L	Mul;		Orgo	in	Food	Lord			
	P ==	ner	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or inju-	ediate ing	Due to (or	as a consequen	ce of):	1						
	be executed icien and burial-transit	Examiner	Cause (Disease or inju- that initiated events resulting in death) Las		C	as a consequent								
60,	be ex icien burial	al E	<b>,</b>		10) 01 600	as a consequent	ce or):							
09289				_	d									
Box	nding use a	M/M	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outco								23d. Date of deliv	verv
_	death e atte	Physician/Medic	in the past 12 mo 1 □ Yes 2 □X	onths?	4□Pregnan	n 2 ☐ Fetal dea t at time of death		Ectopic pre Other (spe					Month	Day Year
P.0.	that the dead by the detached	hys	9 Unknown		9 Unknow									
	Se un es	þ	Part II. Dther significa	int conditions	ontributing to deat		ig in the ur	iderlying ca	use given	in Part I.			1	the cause of death?
oro	w requir been si should	ed	7000	11	46	0/	1070		5~	139	1 🗆 '	Yes 2	□ No 3 Pro	obably 4 🗆 Unknown
3ec	e law has b	Completed	() V/Ta	hetes	MRK	Kitus			/		24a. Was autop	osy /	prior to co	opsy findings available ompletion of cause of
a	sician: The certificate harector, page				/						1 Yes	2 No	death?	2 □ No
Vital Records,	sicial	o Be	25. Was case referred examiner?	-	Hospital:		10		Other		ith (Check only o			
of	g Phys er this eral di	n: To	27. Mayner of Death		28a. Date of I	njury 28t	Outpatient b. Time of		Bc. Injury a Work?	4   Nursing H	ome 5 ☐ Resident 28d. Describe I		6 Other (Speci	ify)
io	nding F ath. r: After e funer	atlo	1 V Natural :	5 Pending investigation		Day Yeer)	Injury	М		s 2 No			,	
Division	r Atte er de recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	Injury - At home, etc. (Specify)	, farm, stre	et, factory,	office		28f. Location (S City or Tox	Street an	d Number or Rur	ral Route Number,
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	Certifying Phy Medical Exam	sician: To the be iner: On the basis and manner	s of examination	dge, death and/or inv	occurred a estigation,	t the time, in my opin	date and place tion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as s	stated. to the cause(s)
	omple	Mec	29b. Signature and little	e of certifier	A d d	piateu.		29c.	License r	number		29d. Dat	e signed (Month,	Dey, Year)
	⊢s⊢ŏ		* X	10/2	1 Ch	m/			D-37	7174			1/2	-104
(			30. Name and address	of person who	completed cause of	of death (Item 23a	a) (Type, F						1	/-/-
1	B3		Song C.	Chon,	MD Cenn	a Medi	cal	Cent	er V	Valdorf	, MD 2	060	2	,
7	Sta		<ol> <li>Date filed (Month),</li> </ol>	Day, Year) IAY 05	32. Regi	strar's Signature	4 /	Cost.	,					
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DHMH 17 Rev 1/2001

Marian Zell

Mark Adams 04-03115 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk. 04-166 State of Maryland / Department of Health and Mental Hygiene RJD Reg. No.2 () () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Adams May 08, 2004 0222A. Mark /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) St. Vincent 8. Date of Birth (Month, Day, 1-26-7. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1XM 2□F Vrs Director 212-56-7162 31 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. Count 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ ST: Vincent Apt. 301 21202 1102 Orleans Street or Iteme 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after al Hygiene. I other than "natural", or Ite 1 Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer Varies 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Lloyd Adams Edna Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m any injury or other traum QDCs. Father 221 E. 91st Street, Brooklyn, N.Y. Lloyd Adams 11212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 5-17-04 Lansdowne, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 Blady Wane March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ue to (or as consequent of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Example Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit the attending physician and Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ₹ Yes 2 No 5 Residence 6 Other (Specify) funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Found , 58 AM 1 Natural 5 Pending 18/04 death. investigation 1 Yes 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined strut co EastHoffme within 24 hours a To the Funerel L To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

THEVOORE

MAY 1 8 2004

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

32. Régis rar's Signature

O.C.M.E.

May 08, 2004

111 Penn Street, Baltimore, Maryland 21201

			For State Registrar	tate of Maryland	_	artment of H			ene g. No. 2	101, 15707
ı	Physicia		Decedent's Name (First, Middle, Last)     Alton Eugene Alber	t, Sr.				2. Date of Death Month May	Day 16	3. Time of Death 7 Year 2004 8:20 A M
,	/Medic Examin		4a. Facility Name (If not institution, give stree	et and number)		4b. City, Town, or		h	4c. County	
			75 Valley Ridge Loc  5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ne hiethday)	Cocl	ceysville		Balti	
	Funeral Director			2□F 63	Yrs.	Months Days	Hours Min.	Jan. 4	Year) 1941	Birthplace (State or Foreign Country)     NC
100	Now H		10a. State 10b. County	10c. City,	Town or Lo	cation			·	10d. Inside City Limits
2	r 28a-f ehow	ctor	MD Baltimore	C	ockey					1 ☐ Yes 2 No
4	a or 2	Funeral Director	10e. Street and Number 75 Valley Ridge Le	200		10f. Zip Code 2103	n .	10	*	What Country?
4	me 23	nera	11. Marital Status 12.	Was Decedent Ever in U.S	i. 13. \	Was Decedent of His f Yes, specify Cubar		pecify Yes or No-	14. Rac	e - American Indian,
036	nous are real with the maryand turel, or teme 23a or 28a-f ebow al Examiner must be notified at	by	1 Never Married 2 Married	Armed Forces? 1		1 Yes, specify Cubar 1 □ Yes 2 X No	Specity:	to Alcan, etc.)	Specify	ck, White, etc. y: white
215-0036	ene. than "natur to Madical	Completed	15. Decedent's Education (Specify only highest grade contents) Elementary/Secondary (0-12)		(Give	ient's Usual Occupa kind of work done d DO NOT use retired)	urina most of wo	rking ·	6b. Kind of B	usiness/Industry
N		Соп	12	n/a	S	ystems A				of MD
	e d al	To Be	17. Father's Name (First, Middle, Last)  Morton Albert					ern Whit		16)
Mar	4 0 - 0	7	19a. Informant's Name/Relationship (Type,			g Address (Street a				State, Zip Code) MD 21030
	f Health item 27 other tr		Nancy K. Albert/w 20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of		Date 2		City or Town, State
altimore,	rages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify) ← p	oval from State		natory`or other place by Valley	1 3/2	0/04 um	Timon	ium, MD
Balti	permit rages Department of Important: If it any injury or one		Bryam W. Clary	ary	22	Name and Address	s of Facility			Valley, Inc. D 21093
F	nysician		23a. Part1. En er the disease, or complications shock, or hear failure. List only one commendate Ca see what disease or con the control of th	ons the t caus the death.	Do not ent	er the mode of dying	, such as cardia	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					>10415
3	s is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):	10 5400	10. 1	1		11
-n	te be executed ysician and ie burial-transit	Examln	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):	lester helli	0 1 Cm 1	<u> </u>		
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	at the death certifics by the attending phatached for use as t	Physiclan/Med	in the past 12 months?	If yes, outcome of pregnan 1□Live birth 2□Fetal of 4□Pregnant at time of dea 9□Unknown	death 3□	Ectopic pregnancy Other (specify)				te of delivery nth Day Year
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Records,	nysician: The law requires that the inside the state of the last been signed by the director, page 2 should be detache	Completed						24a. Was an autopsy perform	ed?	Were autopsy findings available prior to completion of cause of death?
ta		BeC	25. Was case referred to medical examiner?					ath (Check only one	)	
o to	- = a	ို	1 ☐ Yes 2 No	1 Inpatient 2 L		t 3 DOA Othe	r: 4 Nursing F	lome 5 Resider		
Lo	or After	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? ′es 2 ⊟No	28d. Describe how	v injury occuri	red
	or Attending efter death. Director: After d in by the fune	Certification;	2 Could not be	8e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str. City or Town,		er or Rural Route Number,
	vithin 24 hours after to the Funeral Director to the Funeral Director completely filled in	Medical C		an: To the best of my know On the basis of examination and manner stated.						
,	within To the compl	Me	29b. Signature and title of certifier	Ploth	u m P	29c. License	number 1950	3	d. Date signed	d (Month, Day, Year)
	10		30. Name and address of person who comp	leted cause of death (Item	23a) (Type,	Print) ENAKD	Aveal	4 TIMO	NIUM 1	4021093
	Sta Registr	te ar	30. Name and address of person who comp E COSTLO 31. Date filed (Month, Day, Year)  MAY 1 8 2004	32 Registrar's Signatu	ire				- All and a second	

DHMH 17 Rev 1/2001

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		•	For State Registrar		Otato of Maryta		ificate of			g. No. 200	4 15708
Ţ	Dhysisi		1. Decedent's Name (First, I	Middle, Last)	06.11				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	6931 BO	A.	IKACH				MAY 7	2004	1:33 PM
	Examin	er	4a. Facility Name (If not inst. GREATER B.					, or Location of Deat OWSON	n	4c. County of De	
	Funeral	Ą	5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Day	r If Under 24 Hrs		9. Bi	inthplace (State or Foreign
* **	Director		None		M 2□F	Yrs.	violitiis Day	20 17	May 6	0.00/1	MD
	land ow		Usual Residence of Decede  10a. State 10b. Co		10c. (	City, Town or Loca	tion				10d. Inside City Limits
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9	or Iter		1 Never Married 2	Married	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give	;	∕es, specify Cu ∐Yes 2. Xw	uban, Mexican, Puer lo <i>Specify:</i>	to Rican, etc.)	Black, Wh	ite, etc.
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and	be file	Be	17. Father's Name (First, Mi	ddle, Last)		Air		18. Mother's Na	me (First, Middle, M	laiden Sumame)	220.1
Maryla	should nd Men marke umatic	၉	Adetemi 19a. Informant's Name/Rela	ationship (Ty	oe, Print)	19b. Mailing	Address (Stre	et and Number or Ri	ural Route Number,	City or Town, State,	zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene the Health and Mental Hygiene (show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marylan Exeminar mant he redifficated other traumatic event, the Marylan Exeminar mant he redifficated.		Adefemi & Vi	atoria	Ajayi (Parer	nts) 9801	Bridle	e Brook T	DR., Owin	ngs Mills	MD 21117
altimore,	Pages 1 and the notes of the no		20a. Method of Disposition 1 ☐ Burial 2 ★ Crema	ntion 3 □R		Place of Disposi cemetery, crema	tion (Name of tory or other p	lace)	Date 2	Location - City of	or Town, State
<u>=</u>	_ co _		* 4 ☐ Donation 5 ☐ Oth 21. Signature of Funeral Se		(×	25N/1/201	Name and Ado	Programmes of Facility	12004	274 V.16	15,00
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.78	/Medical Examiner		resulting in death)		Due to (or as a cons	equence of):	) Natara	1 suport	L. I land.	burnolis	
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, P.O.	Attending Physician: The law requires that the death certifical refash.  r death.  sctor: Atler this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the funeral director.	by Physiclan/Med	Part II. Dther significant co	enditions cor	ntributing to death but not r	esulting in the unc	lerlying cause	given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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al B	The ficate f			- disal					1 ☐ Yes 2	No 1□Ye	es 2 No
Z:	hysician: The taw his certificate has t I director, page 2 s	To Be	25. Was case referred to mexaminer?  1 Yes 2 No		lospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA	Other	ath <i>(Check only one</i> Home 5 ☐ Resider	nce 6 □Other (Sp	pecify)
n of	ng Phys fter this neral di		27. Manner of Death	Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Vork?	28d. Describe ho	w injury occurred	
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Divi	after of Direct of in by	Certification:	4 Homicide	letermined	building, etc. (Spe	cify)	st, factory, offic		City or Town,		Toral Flobio Hambor,
	To the Hospital or Attending Ph within Z4 hours after death. To the Funeral Director: After th completely filled in by the funeral				sician: To the best of my k						
	the H hin 24 the F mplete	Medical	one)  29b. Signature and title of		and manner stated.			ense number		d. Date signed (Mor	
•	L wit		29b. Signature and line of	eles	Hele-	_ M.D	00	028718			
,			30. Name and address if p	erson who co	ompleted cause of death (I	tem 23a) lype,	int)	19922 1116	11	- Aller	- 04.
			Super Here	6,6h	In Bellie	Medical	and	6701 N.C	intless	Politime	5-MD=120
	Sta Regist	ate rar	31. Date filed (Month, Day,		52. Registrar's Sig	H Anne	20				

				irtment of Health and Mental H	lygiene 2004 15709
	Physici		Decedent's Name (First, Middle, Last)     Lois E. Brown	2. Date of Month	Death  Day  Year  700 M  Day  Year
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  Franklin Square Hospital	4b. City, Town, or Location of Death Rosedale	4c. County of Death, Bottimore
	Funeral Director		5. Social Security Number    191-18-0879	If Under 1 Year   If Under 24 Hrs.   8. Date of Months   Days   Hours   Min.   Apri	Day, Year) Country)
	tryland	_	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Loc		10d. Inside City Limits
	tha Ma 28a-f s postified	Director	MD Baltimore M	iddle River	1 ☐ Yes 2 ☑ No  10g. Citizen of What Country?
	th with 23a or		539 Compass Road	21220	USA
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Itams 23a or 28a-f show event, I've Madical Examiner must be mailfied at	by Funerai	1 Never Married 2 Married 1 Yes \$\[ \] No If Yes, Give 1	Vas Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2 ☑ No Specify:	No- 14. Race - American Indian, Black, White, etc.  SpecifyWhite
200	72 hour natural	eted t	15. Decedent's Education 16a. Decede	ent's Usual Occupation	16b. Kind of Business/Industry
Maryland 21215-0036	filed within Hygiene.  Other than "sent, the was	Completed	12th Hom	kind of work done during most of working DO NOT use retired) IEMAKET	own home
/land	m - 0 3	To Be	17. Father's Name (First, Middle, Last)  James Patrick Scott	18. Mother's Name (First, Midd Catherine T	
Mar	nd 2 sho Ith and I 27 is ma			g Address (Street and Number or Rural Route Num Lannerton Road Bal	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Itam 27 is marked any njury or other traumatic e and any njury or other traumatic e		20a. Method of Disposition 20b. Place of Disposition cemetery, crem	sition (Name of Date latory or other place)  11Cemetery 5/17/04	20c. Location - City or Town, State  Baltimore MD
Balt	permit. F Departm Importar any njur		4.4		lyFuneralHomeofEssex
2	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or respiratory	/ arrest, Approximate Interval Between Onset and Death
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ρĊ,	death certificate be executed e attending physician and ed for use as the burial-transit	i Examine	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):		
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C. BOX	he death certific the attending p thed for use as	Physician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
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Hecord	sician: The law requires that the centificate has baen signad by th inector, page 2 should be datache	Completed	,	24a. Wi au pe 1  Yes	topsy prior to completion of cause of death?
VIIai		Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only	
0	ng Phy Iter this Ineral d	ion: To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient  27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year)  28b. Time of Injury (Month, Day Year)	28c. Injury at Work? 28d. Describ	esidence 6 Other (Specify) e how injury occurred
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Diractor: After completely filled in by the fune.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  28e. Place of Injury - At home, farm, streed building, etc. (Specify)		(Street and Number or Rural Route Number, rown, State)
	e Hospita 24 hours e Funeral etely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death (Check only one)  1 Medical Examiner: On the basis of examination and/or invegence and magner stated.	occurred at the time, date and place, and due to the estigation, in my opinion, death occurred at the time.	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	N		30. Name and address of person who completed cause of death (Mem 23a) (Type, P	2 1 1 5 6 4 / 7	May 12, 2604
	1		Dr. Glenn Meininger 9000 Frankli		- Himore, MD 2/237
	Sta Registr	- 7	31. Date filed (Month, Day, Year)  32. Registrar's Signature	oak	,

			Please  1 - For State Registrar	State of Marylar	nd / Dep	artment of rtificate of	Health and M	ental Hygie	ene 200	4 15710
	Physici		1. Decedent's Name (First, Middle, Las	ory Biniasz		Timoato or	Joann	2. Date of Death Month	Day Year 7 2004	3. Time of Death 2: 45 A M
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give North Arunde) 5. Social Security Number 6. So	treet and number) HOS PITAL  7. Age (In yrs.		Glen	or Location of Death  13 U T 1 P  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug. 24,	Ac. County of Dea Anne A	th / / / / / / / / / / / / / / / / / / /
		Director	Usual Residence of Decedent	10c. Ci	ty, Town or Lo	Glen E				ryland  10d. Inside City Limits  1 □ Yes 2 ☑No
28	ath with ti s 23a or 2 well be n	rai Dire	114 Martha Ro		1		060		usa. Citizen of What C	
11/2	72 hours after death with the Maryland natural, or Items 23s or 28s-f show Jical Examin or most be motified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1X Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu  1 ☐ Yes 2 🟋 No	Hispanic Origin? (Speban, Mexican, Puerto For Specify:	cify Yes or No- Rica <i>n</i> , etc.)	14. Race - Ame Black, Whi	te, etc.
B;	within 72 ene. then "nai	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10th	ucation de <i>completed)</i> College (1-4or 5+)	life.	dent's Usual Occu kind of work done DO NOT use retir tMetalW	•		Bb. Kind of Business Vestingh	
Pana	2 should be filed and Mental Hygi is marked other aumatic event, ii	To Be C	17. Father's Name (First, Middle, Last) Bartholmey B	iniasz			18. Mother's Name Josephin		•	
t. Mary	5 # C #		19a. Informant's Name/Relationship (7 Bernardine Bin	,			a Road G			
Alber 1 Baltimore,			20a. Method of Disposition  ↑ Burial 2 □ Cremation 3 □  ↑ 4 □ Donation 5 □ Other (Specify	Removal from State S+	Place of Dispo cemetery, crei . Stan	osition (Name of matory or other pla islaus	ace)		altimore	
H Balt	permit. Page Department of Important: If any injury or snce.	1.15	21. Signature of Funeral Service Licen	Consil	y	2. Name and Addi	Mace Ave.	Baltim	ore MD	omeofEssex 21221
	Physician /Medical Examiner		23a. Part1. Enter the disease, or company shock, or heart failure. List part of limmediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consect	NA	er the mode of dy	ing, such as cardiac or	respiratory arrest	i,	Approximate Interval Between Onset and Death
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)						
₹ P.O. Box 6	the death certificate y the attending physiched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	]Ectopic pregnanc ] Other (specify) _	э <b>у</b>		23d. Date of del Month	ivery Day Year
	fuires that the de n signed by the a lid be detached t	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.		/	o the cause of death?
of Vital Records,	The law requir ate has been si page 2 should	Completed						24a. Was an autopsy performed 1 Yes 2	d? prior to death?	utopsy findings available completion of cause of
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)	Hospital:		-5 0:	26. Place of Death			
ion of	nding Phys ith. :: After this e funeral di	ation: To	27. Manner of Death  No Natural 5 Pending 2 Accident investigation	Hospital: Inpatient 2   28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	her: 4 Nursing Hom ny at 28 ork? Yes 2 No	e 5 🗌 Residenc 3d. Describe how	e 6 □Other (Specinjury occurred	zify)
Division	ital or Attendii is after death. ral Director: A led in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	y) 			City or Town, S		
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in b	Medical	(Check only 2 Medical Exam	sician: To the best of my knotiner: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my	opinion, death occurred	d at the time, date	and place, and due	to the cause(s)
	With To COL	2	29b. Signature and title of certifier	assalun	MD	29c. Licen	S 5973		Date signed (Month	
			30. Name and address of person who can be seen a seen and address of person who can be seen a	ompleted cause of death (Item	n 23a) (Type,	Print)				ND 20904
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 8 2004	32. Registrar's Signa		las 1.				

DHMH 17 Rev 1/2001

			For State	State	of Mar	yland	/ Depa		nt of H te of L			lental H			200	) 4	15	7 1	
			Registrar				Cei	unca	le oi t	Jeani		2. Date of		g. No.		-	3. Time o	f Death	-
	Physicia	an	Decedent's Name (First, Middle, in the control of the control									Month		Day	Yes	ar			M
	/Medic		Mordeica Ellswo			nam,	Jr.	41 01	T	1	-4 Oceah	May				a a th	9:15	P '	
No.	Examin	er	4a. Facility Name (If not institution, g		umber)			_	, Town, or		or Death			46. 0	County of D	eatri			
			Harbor Hospital  5. Social Security Number 6	. Sex	7 400	(In urs la	st birthday)		imore	If Under	24 Hrs.	8. Date of	Rinh		- 1 9	Ridhola	ice (State	or Fore	
	Funeral			1 <b>∑</b> M 2□F	7. Ago (	75		Months		Hours	Min.	(Month,	Day,	Year)		Countr	zland	0, 1 0, 0,	,
	Director		215-22-0231 Usual Residence of Decedent			/-	,					001.	20,	, 1-	20 1	ICL y	Taria		
	show		10a. State 10b. County		1	10c. City,	Town or Lo	cation								10	d. Inside C	ity Limit	s
	Many	tor	MD Anne Ar	undel		Lint	hicum	1									1 🗌 Yes	2 <b>∑</b> N	0
	r 288	Director	10e. Street and Number						p Code				10	-	en of What	Count	y?		
	death with the Maryland ms 23s or 28s-f show rryst be truffled at		412 Laura Avenue	<u>}</u>				21	090					US	SA				
	deat	Funeral	11. Marital Status	12. Was De Armed F	cedent Ev	er in U.S	. 13.	Was Dec	edent of H	ispanic Or	rigin? (Spe	ecify Yes or Rican, etc.)	No-	1-	4. Race - A Black, W			_	
٥	after des or Itams mirer m		1 ☐ Never Married 2X Married		2 X No	•		1 Yes	3.5	Specify					Specify:	whi			
9500-6121		dby	3 Widowed 4 Divorced	Year or	Dates:				-74										
'n	72 hours 'natural', dicel Exe	Completed	15. Decedent's (Specify only highest		1)		16a. Dece (Give	dent's Us	ork done o	ation during mos	st of worki	ing	1	6b. Kin	d of Busine	ss/Indu	istry		
7	of thin	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)	)				)				Dr	cocto	~ Ci	lov		
_	filed w Hygier other th		12				Sup	ervi	SOL	19 Moth	or's Name	(First, Mid	dlo M			. 51			
ב	d fa b	Be	17. Father's Name (First, Middle, La		1		C						uie, ivi	alueri 3	ourname)				
<u> </u>	should nd Men marke umatic	ို	Mordeica Ellswo		Kingr	nam,			- /0		Krae			0:1	Town Ctn	- 7:- /	Code l		
Maryland 2	0 4 = 5		19a. Informant's Name/Relationship Lillian Eileen E		am /5/7	ifo						d Route Nu. thicun		VID	21090	_	,ooe)		
	s 1 and if Health item 27 other to				an, w.	_	LCe of Dispo		-	ilue,		Date	_		ation - City		m State		
altimore,	0 0 == ==		20a. Method of Disposition  12 Burial 2 □ Cremation 3		n State	Cei	metery, crei	natory or	other plac	1									
Ē			*4 □Donation 5 □ Other (Spe			Mead	dowric				5/17,		-		ridge,				
Ball	permit. Par Departmen Important: any injury		21. Signature of Funeral Service Li	ensee								eral E					_dge :	MP,I	inc
11	& O ≥ € O		1.11									1., E			MD.		075	•-	_
			23a. Part1. Enter the disease, or ca shock, or heart failure. List or	implications that ily one cause on	t caused to each line	he death.	Do not ent	er the mo	ode of dyin	g, such as	s cardiac o	or respirator	y arres	st,			Approxima Interval Be Onset and	tween	
·	Physician		Immediate Cause (Final disease or condition	, /50	HEN	110		FRE	0100	140F	771	44				1	705	EFT	28
	/Medical		resulting in death)	Due to	o (or as a	conseque	ence of):					-+				.>	· CV	= AL	20
	Examiner		Sequentially list conditions.	b. C	N61	EST	IVE	ti	12 Mic	2/-	+H1	LUR	12	-			5 X		
- 3	D #	inel	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a			1	(12 C	00		-170-	-			-	5 x	EHI	40
	and and trans	Examine	that initiated events resulting in death) Last	C	o (or as a			1/=	EFE	PE	186	ASTE	~			1			
Ö,	ate be executed hysician and the burial-transit		, , , , , , , , , , , , , , , , , , , ,	Due (	0 (01 as a	Lonsequi	e co oij.		1										
8760	ate b	dlcai		d	77.77	5-2	-5500000	- A-C											
×	The law requires that the death certific the has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE:	23c. If yes, o	outcome o	f preopan	icv.								0d D-44	-1-1			
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	Fetal	death 3[		pregnancy					2.	3d. Date of Month		y Day	Year	
0	e de the s	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	gnant at ti known	ime or de	alli 5	Other (	specny)										
<u>ď</u>	that the death cer ed by the attendir detached for use	Ph	Part II. Other significant condition	s contributing to	death but	not resul	tting in the u	nderlying	cause div	en in Part	I.	23e. D	id toba	acco us	e contribut	e to the	cause of	death?	$\neg$
S	ires that signed t	by		3				, <b>3</b>				1	☐ Yes	2 🗆	]No 3 [	] Proba	bly 4	Unknow	'n
5	w require been sig	etec											un-	-0.00	041-141				
ec	has to	현										24a. V	vas an utopsy erform	۱ ا	24b. Were prior deat	to com	pletion of	cause of	le i
Division of Vital Records,		Completed										1 □ Ye		No		res 2	2□ No		
Žį.	Attending Physician: Th r death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					Oth	05		(Check or				-			_
5	Physical this all dir	2	1 Yes 2 No	1	Inpatien	-	R/Outpaties 28b. Time o		JUA	4 🗆 N		me 5 ☐ R 28d. Descri				Specify)			-
Ē	ding P. After funer	on	27. Manner of Death  1 Natural 5 Pending	(Mc	te of Injury onth, Day	Year)	Injury	M	28c. Injun Wor	yaı k? Yes 2.⊑		Zau. Descri	De Hot	w injury	occurred				
Sic	tend feath tor: the t	cat	2 Accident investigated a Suicide 6 Could no	t be as Bla	on of Injur	n. At hor	me, farm, st			103 2		28f. Locatio	n /Str	aet and	Numbero	r Rural	Route Nu	mhar	_
₹	f or Attendated after death Director:	Certification;	4 Homicide determin	ed 200. Fla	lding, etc.	(Specify)	)	ieet, iacit	ry, omos			City or	Town.	State)	realizer o	110/0/	110010 7407	11001,	
	urs a	ပိ	One Continue M Continue	Physician: To t	he best of	l mu knou	uladge deat	h cooured	d at the tir	no dato a	nd place	and due to	the ca	uso/s) :	and manne	r ac eta	tod.		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical		xaminer: On the		examinati												s)	
	thin 2	Med	29b. Signature and title of certifier	andine	ariiror stati	1		2	9c. Licens	e number			29	d. Date	signed (M	onth, D	ay, Year)		/
	8 7 % 7		1 1/2	TH.	1.11		41-		18	31	9			C	5/15	12	200	F/	
	J		thell land	belly	an	1 /	232\ (T	Drine's	, 0	7-1		-			1-1			/	
			30. Name and address of person w	no completed ca	mse of de	am (nem	72c		M	ACDI	ELY C	Helci	E	LI	THE		12	20	-
	C+	ate	31. Date filed (Month, Day, Year)	32	Registrar	r's Signat						MIC	14-	VICI		- Charles		)	
	Regist	ate rar	MAY 1 8		20.30	, 1	1 As	31/2	,										

			State of M	aryland / Depa		Health and M	lental Hyg	giene	Jible.	
			Registrar	Ce	rtilicate of	Dealli	2. Date of Dea	leg. No.	UUL	15712
	Physici	an	1. Decedent's Name (First, Middle, Last)				Month	Day	Year	3. Time-or Death (
	/Medic	al	Theodore S. Brinkmann		# 65 To 1	or Location of Death	May	15	2004	10:05P M
	Examin	er	4a. Fecility Name (If not institution, give street and number)					4c. Coun	ty of Death	
			Joseph Richey Hospice  5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthday)	Baltimo		8. Date of Birth	1	9 Birthol	ace (State or Foreign
	Funeral Director		216-18-9134 1★ M 2□F	82 Yrs.	Months Days		8. Date of Birth (Month, Day Feb. 1,	Year)	Mary	ace (State or Foreign try)
			Usual Residence of Decedent	· · · · · ·		1	TCD. I	1722	ilal y	Land
	nytan show	_	10a. State 10b. County	10c. City, Town or Lo	ocation				10	Od. Inside City Limits
	89-1-8	cto	Maryland Howard	Ellicot	t City					1 ☐ Yes 2X No
	ift the	Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen o		try?
	death with the Maryland ms 23e or 28e-f show rmast be notified at	-a	4548 College Avenue		2104			U.S.A		
	er de Items	Funeral	11. Marital Status  12. Was Decedent Armed Forces		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R:	ace - America ack, White, e	
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 1 五 ☐ Yes, 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:		Spec	ity: Whi	ito
Ş	hou		15. Decedent's Education	16a, Dece	dent's Usuai Occui	pation		16b. Kind of	Business/Ind	
7.	n n	Completed	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retire	pation a during most of work ad)	ing			,
120	r tha	E	Elementary/Secondary (0-12) College (1-4or 12)		al Photog	grapher		Medic	al	
Q D	othe vant,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Suma	ame)	
Jar	Aenta Aenta rked ric e	ToE	August Helmuth Brinkmann	ı		Marie Ly	70n			
1005 Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than. Insturat, or items 23e or 28e-f show any injury or other traumatic event, Ite Madical Examinat must be notified at ODCs.		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	t and Number or Run	al Route Number	r, City or Tow	n, State, Zip	Code)
Σ	and 2 saith n 27 I er tre		Holly Hoenes (Daughter)			Avenue El	llicott			
04 nore,	of He of He fitan		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other pla	ace)	Date	20c. Location	- City or Tov	wn, State
15 04 altimore,	Pag nent ant: I		'4 □Donation 5 □Other (Specify)	St. John	's Cemete	ery 5-19-	-2004 E	11icot	t City	, Maryland
15	Departr Departr Importa any inj		21. Signature et Funeral Service Livens e	3 2: U	2. Name and Addre	ess of Facility	of Cot	on arri 1	1 . T.	
	897 29		Barner Lake	The I	630 Edmor	ndson Aver	ue Cato	nsvitt	e, Mar	ryland 2122
5			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not en	ter the mode of dyi	ing, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	-obstructi	repulmo	mary dis	ease			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as	a consequence of):	1	/				
W	Lxammer	L	Sequentially list conditions, b.							
~	ed sit	Examiner	Sequentially list conditions, the sequentially list conditions, the sequential sequentia	a norsequance of):						
	and and I-tran	хап	that initiated events c.	a consequence of):						
IC, IN ( 8760,	be executed ician and burial-transi	caiE	200.10 (0) 20	- u 00/100 quo/100 01/1						
< r	phys the	dic	d							
× ج	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23c. If yes, outcome	of pregnancy				334 C	ate of deliver	D/
≥× 8	atten for u	cian	in the past 12 months?	2 Fetal death 3	Ectopic pregnanc Other (specify)	су				Day Year
C 0.	the d y the sched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		5 0 mar (0p00my/ _					
	that led by deta	y P	Part II. Other significant conditions contributing to death t		nderlying cause gi	ven in Part I.	23e. Did to	bacco use co	ntribute to the	e cause of death?
Sp. Sp.	uires sigr lid be	d by	cerebrovascular disease	-			1 🗆 Y	es 2 🗆 No	3 Proba	ably 4 Unknown
(A) S	The law requires that te has been signed b age 2 should be deta	Completed					24a. Was a	ın 24b	. Were autop	sy findings available
2 8	he la e has ige 2	щ					autops	med?	prior to com death?	npletion of cause of
1 -	ilcian: The lav certificate has rector, page 2		25. Was case referred to medical			26. Place of Deatl		2200	1 ☐ Yes	a⊠No
	Physician: this certific al director,	o Be	examiner?  1 Yes 2 No Hospital: † Inpati	ent 2 ER/Outpatier	nt 3 DOA Ott	hae	me 5 Reside		ther (Specify	Hasnice
	y Phys er this eral di	-	27. Manner of Death 28a. Date of Inju				28d. Describe h	1,000		ricopica
7 5	Attanding Frdeath, actor: After by the funera	ation	1 Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	i <i>y Year)</i> Injury		ork? ]Yes 2 □No				
The Division	Attandi r death, actor: A by the fu	ifica	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, st	reet, factory, office		28f. Location (Si		ber or Rural	Route Number,
70	al or	Certification:	Sullaing, e	tc. (Specify)			City or Town	n, State)		
	hours hours mara y fille		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, deat	h occurred at the ti	ime, date and place,	and due to the c	ause(s) and r	nanner as sta	ated.
	To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only one) 2 Medical Examiner: On the basis of and manner st	ated.	vestigation, in my o	opinion, death occurr	ed at the time, d	ate and place	, and due to	tne cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date sign	ed (Month, D	lay, Year)
	(		> CUO MO		D 2	24170		May	7,20	104
	D		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	5. 1 /L	Baltin	2010 1	C UN	17.01
	Sta	to:	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	n. Cy	~~ S1 ,	2011	-17	-7 -	
	Registi		31. Date filed (Month, Day, Year) 32. Regist MAY 1 8 2004	~ B	back					

			For State Registrar		State of Ma		Department of Certificate of			giene. Reg. No.	2004	15713
	Physici		1. Decedent's Nam Shirley	e <i>(First, Middl</i> e, La Marie Bus					2. Date of De Month May 14	Day	) 4	3. Time of Death 1:15 a M
	/Medic Examin				e street and number)	ce Care	4b. City, Town,	or Location of Dea	ath		County of Death	
	Funeral Director		5. Social Security N 219-68-2	035 6.5		e (In yrs. last birt 50 、		If Under 24 Hr				place (State or Foreign ntry) Land
	yland		Usual Residence o	10b. County		10c. City, Town	or Location				1	10d. Inside City Limits
	8a-fet	ector	MD	Baltimo	re	Baltim						1 Tes 2 10
	3a or 2	I Dir	10e. Street and Nut		t		10f. Zip Code 21220			-	en of What Coul ed State	•
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healin and Mental Hygione. If If the Z1 is marked other than "natural", or Items 23a or 28a-f ehow it If then Z7 is marked other than "natural", or Items 21a or 28a-f ehow or other traumatic event, it is Machical Examitteer must be multified at	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ied 2⊡ Married 4 ☑Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	/	13. Was Decedent of If Yes, specify Cul		Specify Yes or No rto Rican, etc.)		4. Race - Americ Black, White, Specify: White	etc.
0-6121	within 72 ho iene. then "natur re Madical	Completed	(Spec		ducation ade completed) College (1-4or 5	j+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin memaker	during most of we	orking		d of Business/In	
5	be filed tal Hygi d other event, I	Be	17. Father's Name					1	ame (First, Middle		•	
3 7	should and Men s marke umatic	은		erdman Br	<del></del>	19b.	Mailing Address (Stree		olleen H Rural Route Numb			Code)
ž,	and 2 lealth a m 27 ls			y Alcoce	c/Sister		Old Knife					
Dallillor	permit. Pages 1 and 2 Department of Health s Important: If Item 27 li any injury or other tra once.		° 4 □ Donation	©Cremation 3 ☐ 5 ☐ Other (Speci		1	Disposition (Name of y, crematory or other pla Deake Crema	tory	May 15 2004	Belts	ation - City or To sville,	
מפ	permit Depart Impor any in once.		21. Signature of Fu	uneral Service Lice	lell "	NOOTEC.	22 Name and Addr Cremation	ess of Facility Tur En Pastur	neral Alt	terna	tives luimore	, MD
	Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final	a. Acqu		ot enter the mode of dy				rome	Approximate Interval Between Onset and Death
	Examiner	Į.	Sequentially list co	onditions,	b. Due to lor as	a consequence o	dh-					V
	cuted nd transit	Examiner	Sequentially list contains a cause. Enter Under Cause (Disease or that initiated events	S	с.							
,00,0	ate be exe hysiclen a the burial-	edical Ex	resulting in death)	Last	Due to (or as	a consequence o	rf):					
O. BOX 0	The law requires that the death certificate be executed its has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was deceded in the past 12 1  Yes 24 9  Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	зу		23	3d. Date of delive	ery Day Year
COINS, T	equires that en signed b ould be deta	by	Part II. Other signi	ficant conditions	contributing to death b	ut not resulting in	the underlying cause g	ven in Part I.	23e. Did t			ne cause of death?
ב	ician: The law recertificate has be rector, page 2 sh	Completed							1 ☐ Yes	osy ormed? 2 No	24b. Were auto prior to condeath? 1 \( \sum \text{Yes} \)	psy findings available mpletion of cause of 2 No
וסוו טו עונמו	ng Phys fter this ineral di	lon; To Be	25. Was case referexaminer? 1 Tyes 2 27. Manner of Deal 1 Natural	(Ño	Hospital: 1 Inpatie	ry. 28b. T	ime of 28c. Injury	her: 4 🗆 Nursing	Home 5 Resident Resid	dence 6	Other (Specify occurred	w Hospice
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	e Oga Diago of Init	ury · At home, far c. (Specify)	m, street, factory, office		28f. Location (: City or Tou	Street and wn, State)	Number or Rura	ul Route Number,
	e Hospit 24 hour e Funera etely fille	Medical (	29a. Certifier (Check only one)	Certifying P	nysician: To the best of miner: On the basis of and manner sta	examination and	death occurred at the topological death	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) a date and p	and manner as st place, and due to	tated.  the cause(s)
	To the within To the compl	Me	29b. Signature and	title of certifier	1.0			se number			signed (Month,	
	1		30. Name and add	ress of person who	completed cause of d	path (Item 23a)	Type, Print)  N. Char	201	1	ena	y (4)	200K
			W.A.	Riley	GBMC	6701	N. Char	les St.	Balto	ud =	21201	<b>c</b>
	Sta Registr		31. Date filed (	AY"1 '8"20	04 32. Registra	ar's Signature	g Spark	r)				

(a) 12:44 AM

SHIRLEY BUSH - MAY 14, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registrar Amend #5, perFH, g876, 2/25/08 ertificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day BENJAMIN 0238 AM **Physician** WILBERT MAY 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE NIA JOHN HOPKINS If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 05-2 - 1 Birthplece (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 100M 2 0 F -84. SC 0164 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No N BALTIMORE MO Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 4339 NICHOLAS AVENUE Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 MNo 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) LABORER SPARROWS POINT 12 TH GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental HENRY BENJAMIN GRAHAM LULA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARMAINE BENJAMIN 4339 NICHOLAS AVE. BALTO. MD 21206 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Importent: If it any injury or o 1 Burial 2 Cremation 3 Removal from State MT. XION 4 □ Donation 5 □ Other (Specify) 05.19-04 BALTO, MO 21. Signature of Funeral Service License 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE augh 5151 BALTO. NATU PIKE, BALTO. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardial **Physician** intarction 48 HOURS disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Covenavy av term SVEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a c nequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabe 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hypertension page 2 s has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient Certification; To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural hours after death. unerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation in my opinion, death occurred at the time. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year, MO RES-2004 000 MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL, GOONORTH WOLFE STREET, BALTIMORE CHRISTOPHER HOFFMANN

Registrar

State

31. Date filed (Month.)

Day, Year) 1 8 2004 32. Registrar's Signature

04 - 3093per F.H. g834 8/18/04 KBH
Unpend Item #23a,27,28a-f per me G833 //26/04 tas
State of Maryland 7 Department of Health and Mental Hygiene amend 17 per F.H. B.K.S ERIC BAILEY 1 - State Registrer Amend Item #1 per me C831 5/24/04 teaertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Erick Thomas Mceill Daily, Jr. 2. Date of Death Month Day **Physician** 7, MAY 2004 0728 Eric /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UNIVERSITY HOSPITAL BALTIMORE CITY NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**⊠** M 2□ F Yrs. Md. **Director** NA 8 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21201 IISA 407 1102 Druid Hill Ave. Apt. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) NA Infant Infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental b es 1 and 2 should be of Health and Menta Daily Danita Greene Erick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21201 Apt. 407, Baltimore, Md. 1102 Druid Hill Ave. Danita Green Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If itel
any injury or ott 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 5-17-04 Zion Cem. Lansdowne, Md. Qonation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Fignature of Funeral Service Licensee Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ir me ate Cause (Final disease or condition essuling in death) Sudden Unexplained Death in Infancy (SUDI) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day ρ 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 1 ☑ Yes 2 ☐ No 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 5/7/04 7:28  $\mathbf{a}^{\mathsf{M}}$ 1 Yes 2 No Unknown 2 Accident 3 🗌 Suicide 6X Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide University Hospital Pediatric ER Greene Street, Baltimore, MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier fo the 29d. Date signed (Month, Day, Year) MAY 8, 2004 29c. License number 29b. Signature and O.C.M.E no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar THEWORE MIKE

32. Begistrar's Sig

Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May Bivens 8:14 PM 2004 seconious 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Salt imore Hopkins Johns Jospita Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Sex 7. Age (In yrs. last birthday) 5. Social Security Number **№** M 2□ F Md 12-10-63 40 218-94-9263 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 √Yes 2 □ No Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21231 USA 25 N. Patterson Park Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: Black 1 Yes X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owings Mills Car Wash Car Wash 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bivens Williams Seconious Hattie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5249 Cedgate Rd., Baltimore, Md. 21206 Hattie Bivens Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5-18-04 Baltimore, Md. Greenmount Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RETROPERITONEAL HEMORRHAGE Due to (or as a consequence of): IRRHOSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in illustrated events resulting in death) Last HEPATITIS Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2**25**00 3 Probably 4 Unknown 1 ☐ Yes

**Physician** /Medical **Examiner** 

the death certificate be executed

Records,

Division of Vital

Hospital or Attending Physician:

To the

After 1

**Physician** 

/Medical

Examiner

10a. State

Md.

**Funeral** 

Director

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Maryland 21215-0036

Baltimore,

Director

Funeral

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other traumatic event. If a Madical Examiner must be notified at

Examiner physician and the burial-transit Physician/Medical use as į þ cate has been sig Completed director, the funeral Certification; within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

Medicai

4 - Homicide

(Check only

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Impatient

24a. Was an autopsy perform 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

29c. License number KES - 000 29d. Date signed (Month, Day, Year)

30. Name and addres person who completed cause of death (Item 23a) (Type, Print)

Hospital:

600 North Wolfe Street, Baltimore, MD 2128 Brooke Benjamin

31. Date filed (Month

32. Registrar's Signature

State

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

# 2 isoAm Hattie Boyer

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Records,
Vital
of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death  $M_{ay}^{Month}6$ , 2004Year **Physician** Hattie J. Boyer 2:20 AM M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 817 Camp Meade Road Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕅 F 219-10-5723 77 Yrs Nov 8, 1926 Director Maryland Usual Residence of Decedent 72 hours after deeth with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City-Limits 28a-f show other traumatic event. The Medical Examiner must be notified at MD Anne Arundel 1 ☐ Yes 2√ No Linthicum Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 817 Camp Meade Road 21090 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married timore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: white 3 XWidowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) special education teacher education permit. Pages 1 and 2 should be filled.
Department of Health and Mental Hygis important: if item 27 is marked any injury or other 17. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Thomasson Hattie Pearl Dickinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Boyer/son 4937 West Running Brook Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 ∑Donation 5 □ Other (Specify) Ronal Sen 22. Name and Address of Facility Virector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Soquer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed attending physician and Due to (or as a consequence of) Physiclan/Medical use as the IE FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown director, page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No, 24a Was an certificate has 1 Yes 2 No Cherge To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 2 **(X)**No 6 Other (Specify) Hulling Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Natural Injury 5 Pending efter death. Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours e Funeral L 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier name and address of person who completed cause of death (Item 23a) (Type, Print) Mickely 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

8 2004

the Hospitel or Attending Physicien: within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

State Registrar 29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 14,2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year ROBERT PETER BERNOSKI MAY 9:53 15 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 78 Director 217 20 1848 May 14, 1926 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examicar must be neithful at any injury or other traumatic event, the Medical Examicar must be neithful at any injury or other traumatic event. 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 311 Orchard Avenue 21225 U.S. 12. Was Decedent Ever in U.S. Armed Forces?

1∑Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: <u>ک</u> If Yes, Give Korean 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Herbert Electric 12th Pages 1 and 2 should be filed nent of Health and Mental Hygi int: if item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter B. Bernoski Elsie Gorecski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Josephine Bernoski / Wife 311 Orchard Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery ` 4 ☐ Donation 5 ☐ Other (Specify) 5/19/2004 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway romerousale Baltimore, Maryland 21225 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Proysician Hyperkalemia 3 days /Medical Due to (or as a consequence of): Examiner Acute Renal 10-15 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death Month Day 5 Other (specify) 9 Unknown 9 Unknown It signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been irector, page 2 should MYFLODYSPLASIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2 No ANEMIA 1 Yes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOUD May 15, 2004 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER STREET HARBOR HOSPITAL CENTER, BALTIMORE, MD THAHIRA MD AHAMED 32. Registrar's Signature State Registrar

			For State		State of	Marylan		artment of I			•	giene Reg. No. 21	ากเ	15700
			Registrar  1. Decedent's Name (	First, Middle,	Last)			Timodic or	Doan		2. Date of De	-	104	3. Time of Death
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	Examin		4a. Facility Name (If no	ot institution, (	give street and num	ber)	,	4b. City, Town,	or Location	of Death		4c. County	of Death	
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	Funeral Director		<ol> <li>Social Security Num</li> <li>214 82 80</li> </ol>		10 M 2 F 7	'. Age <i>(In yr</i> s. <i>I</i> <b>89</b>	iast birthday) Yrs.	Months Days		Min.	8. Date of Bird (Month, Da Oct. 8	y, Year)	Cou	place (State or Foreign ntry) rvland
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Baltimore,	pernit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Fune	ral Service Lie	Zanie	nusk	//	2. Name and Addr DO1 Ritcl		90	nce Fun y Bal	eral Se timore,	rvice Mar	e, P.A. yland 21225
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DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;		etermined	280. Place	of Injury - I	At home, far pecify)	m, street	, factory, office		28	If. Location (S City or Tox	Street an wn, State	d Numbe )	or or Rural	Route Numi	ber,
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	V		30. Name and address of pe	rson who	completed caus	se of death (	(Item 23a) (	Type, Pri	N. EL	TANI	ST	Ante	30 cf	2 6	till	(IM)	2120
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State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Year 20 **Physician** 12 200 /Medical 4b. City, Town, or Location of Death / 4c. County of Death Facility Neme (If not institution, give street and number, Examiner If Under 24 Hrs. 7. Age (In yrs. lest birthday) B. Date of Birth (Month, Dey, Year) 03/24/1921 If Under 1 Year Birthplace (State or Foreign Country) Security Number **Funeral** Days Hours Months 1 ☐ M 2 🖾 F 215-12-8552 Director Maryland Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Fleath end Mentel Hygiene. tem 27 is merked other than "natural", or hems 23a or 28a-f show other traumstic event, the Medical Examiner must by notified at 1 ☐ Yes 2√3 No Funeral Director NC **Huntersville** 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 16202 Amberfield Drive 28078 U.S.A. Pages 1 end 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White þ 3₺ Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary MD. School for the Blind of Health end Mentel Hygir Iftem 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) æ George J. Hemelt Jr. Anna Marie Kraus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Robert Berkey 2741 Flintridge Drive Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It 1 → Buriel 2 □ Cremetion 3 □ Removal from State Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 5/15/04 Baltimore, Maryland Sacred Heart of Jesus 22. Name and Address of Facility Charles S. Zeiler& Son, Inc. 21. Signature of Funeral Service Licensee any 6224 Eastern Avenue Baltimore, Maryland 21224 23a. Pert1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 4 April Cantuny 1 □ Yes
26. Place of Death Check only one) 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Other: 4 \( \) Norsing Home 5 \( \) Residence 6 \( \)Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 UNO Certification: To this 28c. Injury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Director: After Injury 1 Natural 5 ☐ Pending 1 Yes 2 No death. investigetion 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier edicai completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Roll J. Man. 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 01. Cantin 13 -1 m-2 11 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

**ORIGINAL** 

			State	State of Maryland	Department of Certificate of			giene 199. No. 2004	15723
			Registrar  Decedent's Name (First, Middle, Last)			200	2. Date of Dea	th	3. Time of Death
	Physicia /Medic		Kuth		Rower	)	May	13,2004	12:57 M
	Examin	-	4a. Facility Name (If not institution, give str		. D 11	or Location of Death	4. ,	4c. County of Death	
			5. Social Security Number 6. Sex	7. Age (In yrs. last		more. C	8. Data of Birth	9. Birth	place (State or Foreign
ŀ	Funeral Director			1 20XF 58	Yrs. Months Day		8. Date of Birth (Month, Day April 1		rvland
	pu »		Usual Residence of Decedent  10a. State 10b. County		own or Location				10d. Inside City Limits
	faryla r shov	or							1 ☐ Yes 2 📆 No
	28a-	rect	Maryland Baltimo	re Di	undalk 10f. Zip Code		1	log. Citizen of What Cou	intry?
	h with	Funeral Director	7819 Charlesmont R	oad	21	222		U.S.A.	
	ams :	ner		. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 □ Yes 2 🙀 N	o Specify:		Specify:	ite
21215-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show lical Exscriret must be notified at		15. Decedent's Educa	tion 1	16a. Decedent's Usual Occ	upation	ing	16b. Kind of Business/la	
218	within 7 ene. than "n i.e Med	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work don life. DO NOT use reti	red)			
72	a filed within al Hygiene. other than ' vant, II e Me		17. Father's Name (First, Middle, Last)	2 D	ata Processo	r Supervis		Hospital Maiden Surmame)	
and	build bar if Mental if arkad of atic eva	To Be	James Robert Arch	er			lizabetl		
Maryland	2 should and Men la marka aumatic	<b>}</b> —	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailing Address (Stre	et and Number or Run	al Route Numbe	r, City or Town, State, Zi	p Code)
	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 la marked other than "natural", or itams 23a or 28a-f show if item 27 la marked other than "natural", or itams 25a or 28a-f show or other traumatic event, it is Medical Examinating the notified at		Janet Trimble/Siste		3004 North		Baltime		234
altimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Ref	noval from State cem	e of Disposition (Name of letery, crematory or other p	lace)	ľ	20c. Location - City or T	
Ħ	구두모근		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licenses</li></ul>	Dula	ney Valley C	em.   5/18 tress of Facility	/2004		MD
Ba	permi Depar Impo any ir		1		Mil 641	ler-Dippel 5 Belair R	Funera. oad Ba	l Home, Inc Ltimore MD	21206
			23a. Part1. Enter the disease or complications, or heart failure. List only one	tions that caused the death.					Approximate Interval Between
	Pnysician	R (1	Immediate Cause (Final disease or condition	Pulmonary	hyperte	nsion	s ever	e	Onset and Death
	/Medical Examiner		resulting in death)	Bue to (or as a consequir	nce of):	. <	20.0		IR OD
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	nle of):	Sten	0212		16 years
	cutad od ransit	Examin	Cause, Enter Underlying Cause (Disease or injury that initiated events  c.	Wegen er	5 Granu	10 mato:	sis		18 years
30,	cate be executad obysician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a consequer	nce of):				J
8760,	phy:	dical	d.						
Box 6	eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnanc				23d. Date of deliv	rery
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown				Month	Day Year
P.0	that the de sed by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions contr		no in the underlying cause	awan in Part I	23e Did to	bacco use contribute to	the cause of death?
ds,	9 P 9	d by	Chronic. Pu	Imonary +	_ / / / ·	givan in r with	1 🗆 Y	10	bably 4 Unknown
Records,	w requir been si should	Ψ.	Transport	Slengert			24a. Was a		opsy findings available
Re	The lav ate has page 2	ompiet	- Tacheac	70,103/3			autops perfor		ompletion of cause of 2 No
Vital		Bec	25. Was case referred to medical examiner?			26. Place of Deat			
of V	Physiclan: this certific ral director,	은	1 ☐ Yes 2 No		Voutpatient 3 DOA			ence 6 Other (Speci	fy)
on c		tion:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)		juryat /ork? □Yes 2□No	280. Describe n	ow injury occurred	
Division	deat ctor: y the	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At home			28f. Location (S City or Town	treet and Number or Run	al Route Number,
Ö	tal or A s after al Direc ed in by	Certification:	4  Homicide	building, etc. (Specify)			City of Yow	n, Slatej	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Examine	cian: To the best of my knowledge: On the basis of examination					
	To the I	Med	29b. Signature and title of certifier	and manner stated.	29c. Lice	nse number	2	29d. Date signed (Month,	Day, Year)
	FXFS				REC	2-000		MAY 13, 3	Lags
•	40			pleted cause of death (Item 2	3a) (Type, Print)				
	\			HINS HOPKING F		irth wolfe	STREET, B	SACTIMORE, M	ALYLAND 21287
	Sta Registr		31. Date file (Marth-Dag Year) 04	22. Registrar's Signatur	Son V	/			

04-03232 unpend item#23a,27,28a-f,PFR ME,G833,7/2/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. DEVAUGHNE E BREVARD, JR State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2004 MAY 12, **Physician** 2:00 PM DEVAUGHNE E. BREVARD, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ROSEDALE BALTIMORE CO FRANKLIN SOUARE HOSPITAL 8. Date of Birth (Month, Day, Year)
5 2004 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 X M 2 □ F O Yrs. MARYLAND Director 214-69-2463 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 XNo Director MARYLAND BALTIMORE **ESSEX** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 238 21221 U.S.A. 8 Moline Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or Items Black White etc. e filed within 72 hours after il Hygiene. other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If item 27 is marked other tt any injury or other traumatic event, IIIs once. N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Devaughne Evan Brevard Sr. Marshaun Brevard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parents 8 Moline Circle, Essex, Maryland 21221 DeVaughne & Marshaun Brevard/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK CEMETERY 05-17-04 BALTIMORE, MARYLAND \*4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A.
321 S. PHILADELPHIA BLVD, ABERDEEN, MD 21001 21. Signature Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sudden Unexplained Death In Infancy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ fes 2 ☐ No 24a. Was an autopsy performed? 197 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director. Be examiner Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 5 Pending found 5/12/04 found 1:31p unknown 1 ☐ Yes 2 No after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 8 Moline Circle, Essex, MD found at home within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registra

1 asha Z Greenberz 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

M.D. 32 Registrar's Signature

MAY 1 8 2004

Greenherg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 13, 2004

111 Penn Street, Baltimore, Maryland 21201

Baltimore, Maryland 21215-0036

P.0.

Records,

Division of Vital

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 15725 1 - For Stata Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician**  $P^{M}$ May 13 2004 7:28 Bonnie Michelle Crump /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 617 Dumbarton Avenue Baltimore N/A 8. Date of Birth (Month, Day, Year) NOV 24, 1954 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5 Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🕽 F 49 Yrs. 220-64-4013 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1XYes 2 □ No Director Maryland N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 USA 617 Dumbarton Avenue Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental } John Braxton Ethel Crump ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tam 27 Chanel Crump/Daughter 1410 Cypress Street Curtis Bay, 21226 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 <del>=</del> 1 Burial 2X Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 5 Metro Crematory, Inc. 5-17-04 A □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Leansee

Edward A. Gregorchik Cremation Society of MD, Inc. 299 Frederick Road Baltimore. MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death que) (or as a consequence of): Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the IF FEMALE - Se 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1. Yes 2 No Day for 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Niknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 2 No or Attanding Phyalclan: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other:  $_{4\square}$  Nursing Home  $_{5\square}$  Residence  $_{6}$  MOther (Specify) at SCENE 2 1 XYes 2 No this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital or within 24 hours aft To the Funeral Di 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 14, 2004 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) KILAK 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signartre 31. Date filed (Month, Day, Year) State MAY 1 8 2004

Registrar

December   December	o. 2004 15726 ay Year 3. Time of Death				
Janet Covington   Janet Covi					
May   17   Maiden   Choice   Lane   Catonsville					
The function of the function o	2004 9:52A M				
Social Security Number   Social Security Number   217-20-3552   Social Security Number   217-20-20-352   Social S	c. County of Death				
Supplied   Supplied	Baltimore (State of Formice)				
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City Town or Location 10c. City Town or Location 10c. City Town or Location 10c. City Town or Location 10c. City Town or Locatio	Year) Country)				
10. State   10. County   10. City, Town or Location   10. City Town or Location   10. City Town or Location   10. City Code	23 Maryland				
Elas A. Baugher  Place of Disposition  Secuentially list conditions, it strip leading to death  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Sequentially list conditions, it strip leading to disposition  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Str	10d. Inside City Limits				
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Elas A. Baugher  Place of Disposition  Secuentially list conditions, it strip leading to death  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Sequentially list conditions, it strip leading to disposition  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Str	itizen of What Country?				
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Elas A. Baugher  Place of Disposition  Secuentially list conditions, it strip leading to death  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Sequentially list conditions, it strip leading to disposition  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Str	14. Race - American Indian,				
Elas A. Baugher  Place of Disposition  Secuentially list conditions, it strip leading to death  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Sequentially list conditions, it strip leading to disposition  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Str	Black, White, etc.				
Elas A. Baugher  Place of Disposition  Secuentially list conditions, it strip leading to death  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Sequentially list conditions, it strip leading to disposition  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Str	<sup>Specify:</sup> White				
Elas A. Baugher  Place of Disposition  Secuentially list conditions, it strip leading to death  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Sequentially list conditions, it strip leading to disposition  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Str	Kind of Business/Industry				
Elas A. Baugher  Place of Disposition  Secuentially list conditions, it strip leading to death  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Sequentially list conditions, it strip leading to disposition  Physician / Medical Examiner  Elas A. Baugher  Elas A. Baugher  Elas A. Baugher  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  Nildred Griffith  19b. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Street and Number or Rural Route Number, City  19c. Mailing Address (Str					
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Physician / Medical Examiner  23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to failure plants.  Due to (or as a consequence of):	n Sumame)				
Physician / Medical Examiner  23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to failure plants.  Due to (or as a consequence of):					
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Physician / Medical Examiner  23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to failure plants.  Due to (or as a consequence of):	rel, Maryland				
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Physician /Medical Examiner  Sequentially list conditions, it any, leading to fine edited.  Sequentially list conditions, it any, leading to fine edited.  Director for as a consequence of):  Director for as a consequence of):  Director for as a consequence of):	Approximate Interval Between				
Tarry, Educ (Ledorbing to Ammediate     The 40 (or see a consequence or):	Onset and Death				
Tarry, Educ (Ledorbing to Ammediate     The 40 (or see a consequence or):					
Tarry, Educ (Ledorbing to Ammediate     The 40 (or see a consequence or):					
The state of the s					
The second of th					
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or					
A se thi					
Power in the past 12 months?  1	23d. Date of delivery				
in the past 12 months?    Solution   Solutio	Month Day Year				
9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	use contribute to the cause of death?				
To Yes 2  Hyper tension  1 Yes 2	2 No 3 Probably 4 ☐Unknown				
The same of the significant containing in the underlying case given in Part.  The same of the significant containing in the underlying case given in Part.  The same of the significant containing in the underlying case given in Part.  The same of the significant containing in the underlying case given in Part.  The same of the same of the significant containing in the underlying case given in Part.  The same of the same of	24b. Were autopsy findings available prior to completion of cause of				
The state of the s	death?				
25. Was case referred to medical examiner?  1   Yes   2   No   1   Inpatient   2   EP/Outpatient   3   DOA   Other:  27. Manner of Death   28d Describe how into the control of the contro					
Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence	6 ☐ Other (Specify)				
O a 27. Manner of Death  28a. Date of Injury  28b. Time of 28c. Injury at 28d. Describe how injury  (Month, Day Year)  28b. Time of Injury  Work?  28d. Describe how injury	ury occurred				
O D S S S S S S S S S S S S S S S S S S					
25. Was case referred to medical examiner?  1	and Number or Rural Route Number, te)				
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s					
The property of the property o	ate signed (Month, Day, Year)				
1 1 A. R. O. MULT22	112 /211				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1+107				
	MA 21228				
Densen Boulin mb 711 Maiden Choice Lane, Cutonsville, State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	A - char army have a				
Registrar MAY 1 8 2004 Senera & Social					

n			1 - State of Maryland / State of Maryland / Registrar	_	artment of			jiene 2	004	15	72		
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th		3. Time of	Death		
	Physicia		Terrence Nelson Crummitt				Month May	13	2004	3:10	Ам		
	/Medic Examin	40	4a. Facility Name (If not institution, give street and number)		4b. City, Town	, or Location of De		4c. County of Death					
	_Au,mi	٠,	Howard County General Hospital		Col	umbia		Н	oward				
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last)	birthday)	If Under 1 Yea		Irs. 8. Date of Birth (Month, Day	Voor	9. Birthp	lace (State o	r Foreign		
	Director		220-76-1719 <sup>1⊠M 2□F</sup> 31	Yrs.	Months Day	s Hours M	Oct. 3,			y1and			
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, To		4:					0.4.41102			
	anyla shov	ř		JWII OF LO					1	0d. Inside Cit 1 ☐ Yes	•		
	8a-f	ecto	Maryland Montgomery		7	r Spring					2 140		
	with th	Funeral Directo	100. Street and Number		10f. Zip Code		1	0g. Citizen o		•			
	s 23	eral	1600 Oaklawn Ct.	112.1		20903	/S===#. V====N=		d Stat				
	ltam	Ë	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No	13. 4	Yes, specify Cu	uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ace - Americ ack, White,				
36	irs af	by F	3 Widowed 4 Divorced Year or Dates:	1	l∐Yes 2M∏N	lo Specify:		Spec	ify: W	hite			
21215-0036	e filed within 72 hours after death with the Maryland il Hygiene. other then "neturel", or Itams 23a or 28a-f show vent, Ita Madical Examirat met be millied at	ted		6a. Decec	lent's Usual Occ	cupation		16b. Kind of	Business/Inc	dustry			
7	nin 72	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	(Give life. [	kind of work dor DO NOT use reti	ne during most of v ired)	vorking			•			
27	d with giene ir tha	E	12	5	Salesman	n		Re	tail				
פ	otha otha	Be C	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle, I	Maiden Surna	me)				
<u>lar</u>	should be nd Mental markad c	To E	Ronald Crummitt			Susar	ı	Dead	wiley				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or other traumatic svant, Ita Mudical Examination in the multiple at once.		19a. Informant's Name/Relationship (Type, Print)	9b. Mailin	g Address (Stre	et and Number or	Rural Route Number	; City or Town	n, State, Zip	Code)			
	and 2 salth n 27 i		Susan L. Crummitt / Mother	1600	Oaklav	vn Ct., S	Silver Spr	ing, M	D 209	903			
ore	of He itam		come	of Dispos	sition (Name of natory or other p		Date 17,	20c. Location	- City or To	wn, State			
altimore,	Pages nent of ant: If it ary or o		Brian 2 Community 3 Christian Various State Unito	n Cer	netery or ry Count	of ! III	2004	Spen	cervi]	lle, M	D		
att	permit. Departr Imports any inju		21. Signature of Fungral Service Licensee	22	Name and Add	ress of Facility	Cremation						
m	88 = 88		Stellet Johnnann Moo382	2 9	33 Gist	Ave., Si	lver Spri	ng, MD	2091	0			
	*.		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.							Approximate Interval Bety	ween		
	Physician :	. n	turn data Cours (Circl	trice	o my	100				Onset and D			
	/Medical		resulting in death)  a	ce of):		VICO							
	Examiner		Sequentially list conditions b.										
-	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):									
	acute ind trans	Examiner	that initiated events c.										
Ő,	e exection a	<u>~</u>	resulting in death) Last Due to (or as a consequence	e of):									
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	Physician/Medical	d										
9	eath certific attending pl	Mec	IF FEMALE:										
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnar	ncy			ate of delive lonth	-	'ear		
o.	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5∐	Other (specify)								
σ.	that the death led by the atter detached for u	Ph	Part II. Other significant conditions contributing to death but not resulting	o in the ur	derlying cause (	niven in Part I	23e Did tob	acco use cor	atribute to th	e cause of de	eath?		
ds,	98 Jo	l by		,	idonying oddao (	givoir ii v		s 2 No		ably 4 □U			
Ö	w require been si should I	etec					-						
3ec	e faw has b	Completed					24a. Was a autops perforn	y	. Were autor prior to con death?	sy findings a opletion of ca	vailable luse of		
<u>=</u>	cate							No		2□ No			
<u> </u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:				eath (Check only on						
Division of Vital Records,	Attanding Physician: r death. actor: After this certifici by the funeral director,	2	Tes 2 No 1 Inpatient 2 NER/O	Outpatient  o. Time of	3 ☐ DOA 28c. In		Home 5 Reside			)			
n	ding f h. After funer	Certification:	1 □Natural 5 □ Pending (Month, Day Year)	Injury	W	ork? □Yes 2.25No	duver			hide			
S	or Attandatter deatl	Ca	C Could not be	tarm stre	4		28f. Location (St	reet and Num	ber or Rural	Route Numb	ner		
<u>≥</u>	after Dira	erti	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)			•	City or Town	State		lins!	1		
	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowled	dge, death		time, date and pla	1-0				Q		
	24 h 24 h e Fur etely	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and manner stated.	and/or inv	estigation, in my	opinion, death oc	curred at the time, da	ate and place	, and due to	the cause(s)			
	Fo th vithin ompl	Me	29b. Signature and title of certifier		29c. Lice	nse number	29	9d. Date sign	ed (Month, D	ay, Year)			
	->-0		Josha? Thearles Mp			O.C.M.E.	,	May 13	. 2004	ļ.			
	h		30. Name and address of person who completed cause of death (Item 23a	a) (Type 1	Print)								
			Tasha Z Greenberg M.D.			Street,	Baltimore	, Mary	land 2	21201			
146	s Sta	te	31 Date filed (Month, Day, Year) 92 Registrar's Signature					<del>_</del> _					
altr	Registr	ar	MAY 1 8 2004 America	G	Ano. "								

State of Maryland / Department of Health and Mental Hygiene 200 [ 15728 1 - For State Registre Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** Agnes Bernadine Church May 16, 2004 7:30 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3533 Old York Road N/A Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 252 F Days Months Hours Min 78 Yrs. 219-22-9223 Maryland Director Feb 13, Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Itams 23a or 28a-f show the Medical Exteniner bust be notified at 1 Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3533 Old York Road 21218 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 ☐ Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Hospitality College (1-4or 5+) Elementary/Secondary (0-12) 9 Waitress permit. Pages 1 and 2 should be fil. Department of Health and Mental Hy, Important: if itam 27 la marked otha any injury or other traumant. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Wm. Havnes Celestine Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Henry Church/Brother 3533 Old York Road, Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 20 \* 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 2004 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M80986 Cremation and Funeral Alternatives Hule 8717 Green Pastures Drive Baltimore. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Stag nd Physician /Medical Due to (or as a consequence of) Examiner securities y list concitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed nyoca signed by the attending physician and I be detached for use as the burial-tran Due to (or as a co sequence of): Records, P.O. Box 68760 6 Physiclan/Medical ares ease use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 es 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t page 2 s certificate 1 Yes of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2/ No Certification: To within 24 hours after death.

To tha Funaral Diractor: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Yeer) 27. Manner of Teath 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 055 s of person who completed cause of death (Item 23a) (Type, Print) Bald more m) 21218 Calvart IHANY, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year Physician MAY 2004 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE ATONSVILLE -OREST NURSING HOME If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Funeral Months Deys 1 M 2 VF 215-14-7960 87 Yrs Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiane. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at NA BALTIMORE 1 TYes 2 □ No MD Funerai Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 29TH U.S.A. West 21218 123 STREET 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗷 No Specify: ۵ Specify: BLACK 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) FLORIST FLORAL ARRANGER 8th GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) MC(II)PKIN DANIELS JAM es 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 MARKS MANOR COURT RANDAUSTOWN MD PAULETTE SEWELL-GIBSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If Ital any injury or off 1 □ Removal from State KING PARK CEMETERY OSTOJOH RANDAUSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES 21. Signature of Funeral Service Licenses SISI BALTIMORE NATIONAL PIKE BALTO. MD 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head railure. List only one cause on each line. Approximate Interval Between Onset and Death Physician EREBROVASCULAR DISEASE THEROSCLEROTIL Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or as a consequence of) as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Sther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. DId tobacco use contribute to the cause of death? ABETES 3 Probably 4 Unknown MELLITUS 1 ☐ Yes 2 ☐ No Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yas 28 14 certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral 28c. Injury et Work? 27. Menner of Death 28b. Time of Injury 28e. Dete of Injury (Month, Dey Year) Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Illan

State Registrar **DHMH 16 Rev 6/95** 

new

TASNEEM

31. Date filed (Month, Day, Year) MAY 1 8 2004

30. Name end eddress of person who/completed cause of deeth (Item 23e) (Type, Print)

ARHANY

32. Registrer's Signature

7220

HEIGHTS AVEI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year MAYBELL 2:37 PM CORBIN 2004 MAY 3 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINI Hospital 2-5. Social Security Number 6. Sex of Boltom ORC 1. Age (In yrs. last birthday) Baltimore Lity If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-34 -8749 Months Days Hours 1 ☐ M 2 💢 F MD Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2125 2534 BOARMAN AVENUE U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☑ No Specify: 3 5d Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOMEMAKER 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PLUMMER MANNINGS HATTIE YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE CORBINITR. IOIS WILDWOOD PARKWAY BALTOMD 21229 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 SBurial 2 Cremation 3 Removal from State GARRISON FOREST US/19/04 OWINGS MILLS, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VALGHALC. GREENE FUNERAL SERVICES
5151 BALTIMORE NATIONAL PIKE BALTO MD 21729 21. Signature of Funeral Service License 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac Arrest 5 min Due to (or as a consequence of): Failure Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Universing Cause (Disease or injury that initiated events resulting in death) Last Malsnant
Due to (oras a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

by Funerai

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

al Hygiene.

permit. Pages 1 and 2 Deportment of Health a Important: If item 27 is any injury or other trai once

should be

Baltimore, Maryland 21215-0036

pe attending for use as signed by the a : After al or Attendin after death. I Director: Aft

Records, P.O.

of Vital

physician and s the burial-transit To the Hospital of within 24 hours at To the Funeral D

Physician/Medicai

ģ

Completed

Certification: To

Medical

State

Registrar

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASDESTOS EXPOSURE

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 No 1 Yes 2 XNo

25. Was case referred to medical examiner? 1 ☐ Yes 2√ No

27. Manner of Death
1 Natural
2 Accident 5 Pending investigation 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

RE3-000

29d. Date signed (Month, Day, Year)

who comple ed cause of death (Item 23a) (Type, Print) Charles Matthew
31. Date filed (Month, Day, Year) event, MD, AD

32, Registrar's Signature

MAY 1 8 2004

Hospital of Baltimore

			- Ticus	State of Marvlan	d / Department of I	lealth and Me	ental Hygiene	2000	
		•	1 - For State Registrar	State of Marytan	Certificate of		Reg. No	20114	15731
	Physicia		1. Decedent's Name (First, Middle,	Last)	2011		2. Date of Death Month Da		Time of Death
	/Medic Examin		4a. Fecility Name (If not institution,	give street and number)	4b. City, Town,	or Location of Death		County of Death	
			5. Social Security Number	ch Kaven (e. Sex , 7. Age (in yrs.		SON If Under 24 Hrs.	8. Date of Birth	9 Birtholece	(State or Foreign
ı	Funeral Director		253-10-1091	1□M 2DF	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Year) 1-15-19	10 George	110.
	and w_		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location			10d. Tr	nside City Limits
	Maryli -f eho	tor	11 N	IMORE	BALTIMO	RIF		1	□Yes 2∏No
	or 289	Funeral Director	10e. Street and Number	0 101	10f. Zip Code		10g. Cit	izen of What Country?	
	eath w	eral	11. Marital Status	12. Was Decedent Ever in U.	1	1234 Hispanic Origin? (Spec	ifv Yes or No-	14. Race - American In	dian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23s or 28s-f show any injury or other traumatic event, the Medical Examples must be notified at once.	by Fun	1 Never Married 2 Marrie	Armed Forces?  1 □ Yes 2 No If Yes, Give	.S. 13. Was Decedent of If Yes, specify Cub	an, Mexican, Puerto R Specify:	ican, etc.)	Black, White, etc.	do
21215-0036	2 hours	led b	3 Widowed 4 □ Divorced  15. Decedent's		16a. Decedent's Usual Occu	pation	16b. K	nd of Business/Industry	TC 1
215	within 7. ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d)	1).	0+20	
d 21	filed w Hygie Sthertl	e Co	17. Father's Name (First, Middle, La	ast)	Manager	18. Mother's Name	(First, Middle, Maiden	Sumame)	<u>e</u>
/lan	should be nd Mental marked c	To Be	ARTHUR B	ell		Sara i	Stover		
Maryland	12 sho h and 7 is ma trauma	1	19a. Informant's Name/Relationship	and do	19b. Mailing Address (Street	and Number or Rural	Poute Number, City of	r Town, State, Zip Code	21221
_	s 1 and f Health item 27 other tr		20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other pla	Ce) Da	20c. Lo	ocation - City or Town, S	State
altimore,	t. Pages rtment of rtant: If it njury or o		1  Burial 2  Cremation 3 1  Other (Spe	Hemoval from State	on Grove Cemete	Ry 5-16	5-04 Fai	on GROVE	, PA
Balt	permit. Departr Importu any inji		21. Signature of Funeral Service Li	Sensee 2011	22. Name and Addre	ss of Facility BAC	FIMORE, A	1D Z1234	1.
-			23a. Part1. Enter the disease, or or shock, or heart failure. List or	Emplications that caused the death	h. Do not enter the mode of dyi	ng, such as cardiac or	APEL, 8800 respiratory arrest,	App	roximate rval Between
	Physician	1	Immediate Cause (Final disease or condition	ny one cause on each line.	gana)	sene 1	of leas		et and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	1/	H 11	1		
	\$*.	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consent	verice of):	mullo	V		
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	uspec of):				
760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	cal E		d	dence of).				
68	ntificating phy		IF FEMALE:						
Box	eath ce attendi	by Physician/Med	23b. Was decedent pregnant in the past 12 ponths?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	I death 3 Ectopic pregnanc	у		23d. Date of delivery Month Day	Year
P. O.	it the d by the tached	hysi	1 ☐ Yes 2 M No 9 ☐ Unknown	9□ Unknown					
ds, F	The law requires that the death certifica ate has been signed by the attending phrpage 2 should be detached for use as the		Part II. Other significant condition	s contributing to death but not resi	ulting in the underlying cause gr	ven in Part I.	1 2	se contribute to the cau X No 3 Probably	use of death? 4 Unknown
Vital Records,	aw req is been 2 shou	Completed					24a. Was an	24b. Were autopsy fi	ndings available
= E	The law cate has I	Com					autopsy performed? 1 ☐ Yes 2 2 No	death?	
	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🗶 No	Hospital:	ER/Outpatient 3 DOA	26. Place of Death	(Check only one) e 5 🗆 Residence	2 1701-1-101-1-1	-
Division of	Attending Physicien: r death. ector, After this certifice by the funeral director. p	on: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wo	ry at 28	8d. Describe how injur		
SIO	ttendir death. tor; Al	icatic	2 Accident investiga 3 Suicide 6 Could no	t he		Yes 2 □No	of Location (Street an	d Number or Rural Rou	to Alumbor
DIV	s after all Direct all	Certification:	4 Homicide determin	building, etc. (Specify	y)		City or Town, State	)	re womber.
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	Medical		Physician: To the best of my kno caminer: On the basis of examinal and manner stated.					ause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Tunst	29c. Licens	4	29d. Dat	e signed (Month, Day,	Year)
,	X		30. Name and address of person W	completed cause of death (Herr	7	015414		0/10/2	-004
			VWW F VU	NGU YEN	6331 Below	rkol B	altimo	M 21.	206
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	tyre boards				
	riegisti	ear .	MAY 1 8 2004	1 cope of	13				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Alberta Cimmino 3:50 PM M May 12, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Devlin Manor Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F 209-05-7975 86 Dec 4, 1917 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10301 Christie Road NE 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clerk restaraunt/liquor store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Frank DeMarco

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic avant, the Medical anse.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

\*natural", or Itams 23a or 28a-f ahow adical Examinational by notified at

Director

Funerai

Completed by

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Examiner by Physician/Medical Be Completed Medical Certification: To

After this certificate

To the mospinal within 24 hours after death.

To the Funeral Director; Aft

Division of Vital Records, P.O. Box 68760,

19a. Informant's Name/Relationship (Type Robert Frame/frie		A CONTRACTOR OF THE CONTRACTOR		al Route Number, City or Town, State	, Zip Code)
Robert Frame/111e	11 <b>u</b>	140 POIK SU	reet Cumber	land, MD 21502	
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)		Place of Disposition (Name commentary, crematory or other		Date 20c. Location - City	or Town, State
21. Signature & Funeral Service Licensee	ades Director	State A Baltimo	ddress of Facility natomy Boar re, MD 212	d 655 W. Baltimor	e Street
23a. Part V. Enter the disease, or complicing shock, or heart failure. List only one Immediate Cause (Final		h. Do not enter the mode o	dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as a consec				yrs-
Sequentially list conditions b. if any, leading to immediate	Due to (or as a consec		MIRE		yrs_
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	urance of):			
d.	Due to (or as a consec	uence or):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of co 9 ☐ Unknown	il death 3 ☐Ectopic pregr		23d. Date of o Month	delivery Day Year
Part II. Dther significant conditions cont	ibuting to death but not res	sulting in the underlying caus	e given in Part I.	23e. Did tobacco use contribute	to the cause of death?  Probably 4 Honknown
				autopsy prior t performed? death	autopsy findings available o completion of cause of ? es 2 100
25. Was case referred to medical			26. Place of Deat	h (Check only one)	
examiner?	spital: 1   Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Hursing Ho	me 5 Residence 6 Other (S	pecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory, of (y)	fice	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examina	cian: To the best of my know: On the basis of examinations and manner stated.	owiedge, death occurred at tation and/or investigation, in	he time, date and place, my opinion, death occur	and due to the cause(s) and manner red at the time, date and place, and d	as stated. ue to the cause(s)
29b. Signature and title of Califier		29c. L	cense number	29d. Date signed (Mo	nth, Day, Year)
30. Name and address of person who con	32. Registrar's Signi	l'ahvan	La Valer	MD 2150	2

State

Registrar

MAY 1 8 2004

			i lease i	State of Ma	rvland /							aiene	ecgibio	••		
		•	For State Registrar	Otato or ma	il y latina i		tificate			21 1G 171C			200	4	15733	
			Decedent's Name (First, Middle, Last)							2	2. Date of De	ath			3. Time of Death	~
	Physicia /Medic		Elizabeth Kelly Ch	${ t ildress}$							Month May 1	Da 2	y Ye 2004	ar	7:59 P M	
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death			. County of D	eath		
			Greater Baltimore					wson					altimo			
	Funeral		5. Social Security Number 6. Sec. 10	7. Age ]м 2 <b>[X</b> ] F	(In yrs. last b	virthday) Yrs.	If Under Months	Days	If Under a	Min.	B. Date of Bird (Month, Da Dril 2	y Year)	L921 9.	Count Count	ace (State or Foreign	
L.	Director		Usual Residence of Decedent							ĮA.	brii z	.∪, .	1921	теп	nessee	_
	ylend how		10a. State 10b. County		10c. City, To									10	d. Inside City Limits	
	9 Ma	cto	Maryland Baltimor	e	Lutr	nerv.	ille							<u></u>	1 ☐ Yes 2 X No	_
	be filed within 72 hours affer deeth with the Marylend at Hygiene. A let Hygiene and the than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 15 Ridgefield Rd.				10f. Zip	1093				_	izen of What Inited		-	
	ns 23	eral		12. Was Decedent E	ver in U.S.	13.				gin? (Spec	ify Yes or No ican, etc.)		14. Race - A	merica	n Indian,	_
٥	or iter		1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 📉 N	lo		lfYes, spec 1 ☐ Yes :		n, Mexican Specify:	i, Puerto Ri	ican, etc.)		Black, V	_		
3	irai', c	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:									Specify:			
<u>7</u>	n 72 h "natu	Completed	15. Decedent's Edu (Specify only highest grad		16.	(Give	dent's Usua kind of wor DO NOT us	rk done d	luring most	t of working	7	16b. K	ind of Busine	ss/Ind	ustry	
7	filed within 72 Hygiene. other then "natent, the Wedic	duc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		creta		,				churc	ch		
ק ס	filed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)				02000		18. Mothe	er's Name (	First, Middle,	Maider				-
Ian	n = 9 a	To B	Milton Richard Kel	ly Sr.					01i	ive Fe	erguso	n				
Maryland 21215-0036	is 1 and 2 should of Heelth and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T)				ng Address idgef				Route Numbe thervi			2109	_	
-	1 and Heelth em 27 ther t		William M. Childre  20a. Method of Disposition	SS/HUSDAIR	20b. Place	of Dispo	sition (Nan	ne of	1	Da			ocation - City			_
Baltimore,	permit. Pages 1 s Department of He Importent: if Item any injury or oth		1 ☐ Burial 2 X Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)			-	matory or o			au 10	2004	Ra	1 t i moı	۵^	Maryland	
Ħ	mit. Poartme		21. Signature of Funeral Service Licens	00	Green		Name an	d Addres	s of Facilit	v						-
ä	Per Imp		Julie O. Mitche				M1 65	tche 00 Y	ork F	redere Rd.	eld Fu Balti	nera more	HOMe MD	212	nc. 212	
П			23a. Firt1. Enter the disease, or complete on complete on the control of the cont	ications that caused ne cause on each	the death. Do	o not ent	er the mod	e of dying	g, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death	
	Pnysician	8 4	Immediate Cause (Final disease or condition resulting in death)	ath	evos	ce	Wes	1					157 8	/	U yeller	
Б	/Medical Examiner		resulting an obality	Due to (or as a	a consequence	e of):										
	10	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence	Θ of):										
	aafh certilicate be execufed affending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c												
760,	te be execufed ysician and e burial-transit		resulting in death) Last	Due to (or as a	a consequenc	e of):										
6876	physic the p	dlcal	•	d										-		
9 XO	certifi ding	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of	deliver	y	
m	deafh a affer d for u	Iclar	in the past 12 months?	1 Live birth 4 Pregnant at	_		⊒Ectopic pr ⊒ Other <i>(sp</i>						Month	1	Day Year	
0.0	that the de ned by the a detached t	Physician/Med	9 Unknown	9□ Unknown							T		200 1 1 1 1 1			-
	The law requires that the death certifical te has been signed by the affending phoage 2 should be detached for use as the	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the u	nderlying c	ause give	en in Part I.	•					bly Unknown	
Records,	requir	Completed	aque	C						<del></del>						_
3ec	has b	mple	CA				-				24a. Was autor perfo		24b. Were prior deat	to com	sy findings available pletion of cause of	
						-			00 81		1 ☐ Yes	2 Spice			2 🗆 No	_
Vita	sicial certi	o Be	25. Was case referred to medical examiner?	Hospital:	nt DER/O	Outnatie	nt 3 DC	Othe	200		(Check only o		6 □Other /	Specify		
o	g Physer this eratidic	-	27. Manyler of Death	28a. Date of Injur (Month, Day		. Time o		8c. Injury Work	_	-	3d. Describe I			poony		
ion	Attending Physician: or death. ector: After this certifici by the funeral director,	atlo	Natural 5 Pending investigation				М	1 🗆 '	Yes 2 🗆	No						
Division of	or Attencaffer deaff Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, c. (Specify)	farm, st	reet, factory	, office		28	Bf. Location (S City or Tox			r Rural	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funere! Director: After this certific completely filted in by the funeral director.		29a, Certifier Certifying Phy	vsician: To the best of	of my knowled	lge, deat	h occurred	at the tim	ne, date an	id place, ar	nd due to the	causale	) and manne	r as sta	ited.	_
	e Hos 24 hc Fun etely i	edical	(Check only one) 2 Medicel Exam	iner: On the basis of and manner sta	examination a	and/or in	vestigation	, in my or	oinion, dea	th occurred	d at the time,	date an	d place, and	due to	the cause(s)	
	To the within To the	Me	29b. Signature and Itle of certifier	11111		112	290	c. License	e pumber	20		29d. Da	te signed (M	onth. D	lay, Year)	
-	1.		1 1 molling	ulla	we h	1		13,	704	7						
	10		30. Name and address of person who o					D =	om 21	12						
			Rodney Williams  31. Date filed (Month, Day, Yeer)		01 N.Ch ar's Signature	ario	es St	. Ko	JII 32	1.)						
	Sta Registi		S1. Date filed (Month, Day, Feer)		pull A	9	Loa	de	/							

State of Maryland / Department of Health and Mental Hygiene

				State of Ivia			ificate of			Reg. No. 2	nnu i	5731
П	Physici	an	1. Decedent's Name (First, Middle, Lest,						2. Dete of De Month		3. Tin	ne of Death
4	/Media		James Henry						May		$004 \mid 11:$	45 PM
J.	Examir	er	4a Fecility Neme (If not institution, give					71 70 70 70 70 70	Location of Deat			
_	<b>-</b>		Forest Haven Nursi  5. Social Security Number 6. Sec		(In yrs. lest b	oirthdev)	If Under 1 Year	Catonsv			1 Sirtholace (St	ate or Foreign
	Funeral Director			M 2□F	83	Yrs.	Months Days	Hours Mir		0, 1920	9. Birthplace (St Country) Maryland	dio or y oraign
	yland		10a. State 10b. County		10c. City, To	wn or Loca	ition				10d. Insid	de City Limits
	Mar	ż	Maryland Anne Aru	ndel	Hano	ver					1 🗆	Yes 2 No
	th with the 23a or 28 unt be not	al Dire	10e. Street and Number 1611 Deer Meadow	Court			10f. Zip Code 2107	6		10g. Citizen of V United	What Country?  I States	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show airportant: if item 27 is marked other than "natural", or items 23a or 28e-f show airping injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates:			as Decedent of Horses, specify Cub		Specify Yes or No rto Rican, etc.)	ify Yes or No- lican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White		
5	natu dicel	etec	15. Decedent's Edu- (Specify only highest grede	cation completed)	16	a. Deceder (Give kir	nt's Usuel Occup nd of work done	pation during most of we d)	orking	16b. Kind of Bu	siness/Industry	
21215-0020	filed within Hygiene. rther than "	ошрі	Elementary/Secondary (0-12)	College (1-4or 5+	) Ma			ø) achinist		AT&T		
P	al Hyd	Be	17. Fether's Neme (First, Middle, Lest)						me (First, Middle		е)	
yla	2 should be to and Mental I is marked of raumatic eve	2	Goley R. Dick					Bernard	ine Hoer	nig		
, Maryland	1 and 2 sh Health and em 27 is m other traum		19a. Informant's Name/Relationship (Ty. Rosemarie Dick - W			_			iure <i>l Route Numb</i> t Hanov			076
Baltimore,	Pages 1.		20a. Method of Disposition	emoval from State	1		ion (Name of tory or other pla e Mem.		Date 5/17/04		City or Town, Stat ge, Mary]	
Balt	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service License	90		Gar 725	Name and Addre y L. Ka O Washi	ss of Facility ufman Fu	neral Ho ulevard	me At MM	MP., Inc.	21075
			23a. Pert1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the	ne deeth. Do						Approx	
}	Physician /Medical Examiner	8	Immediate Cause (Final disease or condition resulting in death) e	ASPI	RATIO	N	PNEU	MONIF			Onset	and Death
	uted d ensit	Examiner	Sequentially list and divine		ue to (or as a							
68760,	rificate be executed ng physician and es tha bunal-trensit	cal Ex	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events									
		Physician/Medical	resulting in death) Last		ue to (or es e	conseque	nice or).				i   	
Вох	eath cert attendin for use	Clar	Basil Oshan da Manasa and Malana						004 814		1	
P. 0.	res that the dei igned by the a be detached f		Part II. Other significant conditions con  A 22 HEIMER		not resulting	in the unde	eriying cause giv	en in Part I.		./	tribute to the cau	
Vital Records,	aw requii is been s 2 should	Completed by								an autopsy med?	24b. Were autop available pr completion of death?	rior to
æ	The it	Ĕ							101	ras 2121No	1 ☐ Yes	2 No
ita		Be (	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o	ne)		
-	S 50	P	1 ☐ Yes 2 ☐ No ☐ H  27. Manner of Death  11 ☐ Neturel 5 ☐ Pending	ospital: 1  Inpatient 28e. Date of Injury (Month, Dey 1		utpatient Time of Injury	3 DOA Oth	41 4 Nursing I	Home 5 Resid	dence 6 Othe		
Division	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 ☐ Accident investigetion 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At home, f	arm, street		Yes 2 No	28f. Location (S City or Tow		er or Rural Route	Number,
	ital or irs after rai Dir lled in	Ce	/									
	n 24 hot n 24 hot ne Funei pletely fil	edicai	29a. Certifier (Check only one)  1□ Certifying Phys 2□ Medical Examin	ician: To the best of a er: On the basis of ea and manner stete	xamination er	e, death oo nd/or inves	ccurred at the tire stigation, in my o	ne, date end place pinion, death occu	e, and due to the ourred et the time,	cause(s) and mar date and place, a	nner as steted. nd due to the cau	se(s)
	Vithi Comp	N	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed	(Month, Dey, Yee	er)
	0		Jasneen da	elehan			03	18595		5/17/0	94	
	/,		30 Neme end address of person who con	mpleted cause of dea	th (Item 23a)	(Type, Pri	HEI CH	3 Ave	BART	D MD	21208	2
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrer	s Signature		.0					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			. For	State of Maryland / Department of Hea	Ith and Menta	Hygiene		
			State Registrar	Certificate of De-	ath	Reg. No.	2001	15735
	Physicia	an	Decedent's Name (First, Middle, Last)	N :=	Mon		Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give st	eet and number) 4b. City, Town, or Loc	Pation of Death	-	County of Death	03294
	Examin	er		Kins Hospital Baltimo	- 41		Λ	1/14
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs, last birthday) If Under 1 Year If U	Under 24 Hrs. 8. Date	of Birth	9. Birth	place (State or Foreign
ı	Director		727-18 2016.	Yrs. Months Days Ho	06	-21-19.	35 GC	rgiA
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
	Mary a-f sh	tor	MD NI	7 Baltimo	re			1 Yes 2 □ No
	ith the	Direc	10e. Street and Number	10f. Zip Code	21/1/	10g. Citiz	en of What Cou	intry?
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f show ont. The Medical Evarit writing Let coulified at	Funeral Director	0012 10	Was Based at Street in U.S. 12 Was Based at differen	2 TT	or No. 1	4. Race - Amer	. I T
	fter da	Fune	11. Marital Status  1 Never Married 2 Married	. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 No	lexican, Puerto Rican, e	tc.)	Black, White	
2-0036	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1 ☐ Yes 20 No Sp	pecify:		Specify: $ ot\! E$	SLACK.
2	72 ho natu	Completed	15. Decedent's Educa (Specify only highest grade	tion 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	ng most of working UN	16b. Kin	d of Business/I	ndustry UNI
121	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)				
2	filed w Hygier other th	Be Co	17. Father's Name (First, Middle, Last)	18.	Mother's Name (First, I		4	_
Maryland	should be nd Mental marked c	To B	JOSEPH .	1) AU 15	Naom,	Kil	ch AR	ason
fan J	2 sho and I Is me		19a Informant's Name/Relationship (Typ	(Print) 19b. Mailing Address (Street and N	Number or Rum Poute	Number, City or	Town, State, Zi	p Code)
	1 and 2 Health tem 27		20a. Method of Disposition	20b. Place of Disposition (Name of	Date	20c. Loc	ation - City or T	own. State
Baltimore,	of of It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State  Metro Cercity	5/17/0	4 M	ARU/	120
E a	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	22. Name and Address of	Facility Lote	11 Ju	nerue	Home
<u>~</u>	Departing Department of the particular in the pa		Wille EH	xull 4600 hoses	Ty Her	Baux	). Mp	21207
			snock, or neart failure. List only one			1	1	Approximate Interval Between Onset and Death
	Physician /Medical	Н	Immediate Cause (Final disease or condition resulting in death)	Asystolic cardiac	arrest			50 minutes
Ĺ	Examiner			Due for is a consequence of):				1 month
		Jer	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				, ,,,,,
	acuted and transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
8760,	ficate ba executed physician and sthe burial-transit	ai Ex	resulting in deathy Last	Due to (or as a consequence of):				
687	ficate p phys	edicai	d.					
XO	Physician: Tha law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		2	3d. Date of deliv	,
Vital Records, P.O. Box	e deat he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at time of death 5 □ Other (specify)			Month	Day Year
<u>Ч</u>	hat the	Phy	9 Unknown	ibuting to death but not resulting in the underlying cause given in	Part I. 23e	. Did tobacco us	se contribute to	the cause of death?
ds,	uires tha signed d be det	d by	None			1 ☐ Yes 2	No 3□Pro	bably 4 Dunknown
COL	s been si should	Completed			24a	. Was an	24b. Were aut	opsy findings available
Re	Tha lav	mo:			10	autopsy performed? Yes 2 No	death?	ompletion of cause of
ital	cian: artifica ictor, p	BeC	25. Was case referred to medical examiner?		. Place of Death (Check	only one)		
0	Physic this call dire	<sup>2</sup>	1 ☐ Yes 2 No		Nursing Home 5	Residence 6		fy)
no	ding f h. After funer	tion	27. Manner of Death  1	(Month, Day Year) Injury Work?	2 No	cribe now injury	occurred	
Division of	Attan r deal ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loca	ation (Street and or Town, State)	Number or Rui	al Route Number,
Ö	tal or rs after al Dir	Certification:	4 ( Tromode	building, atc. (Specify)	Ony	or rown, blate)		
	To the Hospital or Attanding Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier Check only one) Certifying Physical Examin	cian: To the best of my knowledge, death occurred at the time, doesnot be basis of examination and/or investigation, in my opinion	late and place, and due on, death occurred at the	to the cause(s) a time, date and	and manner as place, and due	stated. to the cause(s)
	o tha o tha omple	Med	29b. Signature and title of certifier	and manner stated.  29c. License nur			signed (Month	
)	- × - ō		1 Container R	Clausino RES-	000	MAY	14,20	say
	10		30. Name and address of person who cor	pleted cause of death (Item 23a) (Type, Print)			14/00	107
	10		Courtney Bellaus	The John Hopkins Hosp	ital 600 N	Wolfe	74 Ra14	0,MDZ1287
	Sta Registi		31. Date filed (Mbnth, Day, Year) MAY 1 8 200	32. Registrar's Signature  Server & Assault	7			

			1 - For State Registrer	State of M	aryland / Depa <i>Cei</i>	artment of H			giene 20	04 15738
	Physic	ian	1. Decedent's Name (First, Middle, Last	)				2. Date of Dea	ith	3. Time of Death
,	- /Med	cal	Ruth Anne 4a. Facility Name (If not institution, give	ctroat and sumbarl	Dav			May		12:47 P
	Exami	ner	Mariner Health of		nie	4b. City, Town, or Glen Bu		1	4c. County o	
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9 Birtholace (State or Foreign
	Director		214-46-2275	JM 2∰ F	90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Mar. 26	, Year) 1914	9. Birthplace (State or Foreign Country) Virginia
	and w		Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	action				
	death with the Maryland ms 23a or 28a-f show	5	MD Anne Aru	ndo1						10d. Inside City Limits 1 ☐ Yes 2√☐ No
	28a-	rect	10e. Street and Number	maer	Glen Burn	10f. Zip Code			IOG Citings of M	
	h with	Funeral Director	230 Ferndale Road			21061			log. Citizen of W	
	death	nera	11. Marital Status	12. Was Decedent	Ever in U.S. 13. )	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No-	U.S.A	- American Indian,
9	after or Ite	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2771 If Yes, Give	NO	_		Rican, etc.)	Black	, White, etc.
5-0036	72 hours atter natural', or Ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		I∐Yes 2√∏No	Specify:		Specify:	white
15	in 72 n "nal	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of worl	king	16b. Kind of Bus	iness/Industry
2121	f within piene. r than "	Eo	Elementary/Secondary (0-12)	Cotlege (1-4or 5	+)		erator		Davie Ma	anufacturing
	be filed tal Hygid d other	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam			
/lar	should be nd Mental marked o	To B	Edward Labin Dav	is			Lucy	Shumate		
Maryland	and and ls m		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a			, City or Town, S	itate, Zip Code)
	1 and Health Iem 27		Mr. Howard W. Davi	s, Jr. /	son 9184 1	Rollingme	adow Run	, Pasade	na, MD 2	21122
Ore	ges 1 ar f of Hea if item or other		20a. Method of Disposition 1 ABurial 2 Cremation 3 R	emoval from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	)	Date	20c. Location - C	city or Town, State
Baltimore,	t. Pa rtmen rtant:		`4 □ Donation 5 □ Other (Specify)		Louden Pa	ark Cemet	ery May	14,2004	Baltimor	e, MD
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licens	n	M 12/00 1	Name and Address	of Facility Si	ngleton	Funeral	Home P.A.
			23a. Part 1. Enter the disease, or compli	cations that Faused	the death. Do not ente	Second A	venue S.	V., Glen	Burnie,	MD 21061
	Dhysisian		shock, or heart failure. List only or Immediate Cause (Final	ne cause of each lin	Θ. , //	//	t /	or respiratory arre	3St,	Approximate Interval Between Onset and Desch
1	Physician /Medical		disease or condition resulting in death)	THE C	a consequence of):	20ml	Fin/U	re		Lucel
Р	Examiner			Str	Le					BUPart
	D ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Que to (or as a	consequence of):					3
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Ulme	2019					Jyears
60,	icate be executed physician and s the burial-transit	E E	rosulting in death) cast	Due to (or as a	a consequence of):					
68760,	icate be execute physician and s the burial-trans	edical	d							
Box (			IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	of pregnancy					
m	death s atter	Physician/M	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐ I	Ectopic pregnancy Other (specify)			23d. Date of Month	
0.	at the de by the i	hys	9 Unknown	9□ Unknown						
S, P	law requires that the death certi as been signed by the attending 2 should be detached for use a	by P	Part II. Dther significent conditions con	tributing to death bu	t not resulting in the un-	derlying cause giver	in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
ord	w requir been si should I							1 ☐ Ye	s 2 46 3	☐ Probably 4 ☐Unknown
Vital Records,	e faw i has be je 2 sh	Completed						24a. Was an autopsy		re autopsy findings available or to completion of cause of
E H	Th ate pag	Con						perform	ed? dea	ith?
Vit	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death			
of		5. 70	1 Yes 2 No	1 Inpatier		3 DOA Others	4 Lansing Hor	ne 5 Resider		
on	Attending Ph r death. ector: After thi by the funeral	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Infury	Work?	s 2 No	28d. Describe how	w infury occurred	
Division		iffice	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	ry - At home, farm, stree			28f. Location (Stre	et and Number	or Rural Route Number.
	tel or rs afte al Dir	Certification;	Tiomole	building, etc.	(Specify)		9	City or Town,	State)	
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 tifying Physic (Check only 2 Medicel Examin	ician: To the best of	my knowledge, death a examination and/or inve	occurred at the time	, date and place, a	and due to the cau	use(s) and mann	er as stated.
	To the P within 2 To the P complete	Medical		and manner stat	ed.			ed at the time, dat	e and place, and	I due to the cause(s)
)	Z × Z	-	29b. Signature and title of certifier	& hat	-,	29c. License r		29	d. Date signed (A	Month, Day, Year)
7	11		Eccesy 1		m	020	0094	- (	03/11/0	04
	5		30. Name, and address of person who com		ath (ftem 23a) (Type, P	40 dida	Par	K Drus	110	Burnigmd, 2106)
	Sta	е	31. Da Mila Manth Day, Year)	404)	's Signature	10 1100		1	4 Cuch	-11, -14, 2166)
E	Registra	ar	/	plane	D So	ale				

			For State	State of Ma	aryland /			of Health a				4 15737
			Registrar  1. Decedent's Name (First, Middle, Last	)			inoute	or Doutin		. Date of Deat	h	3. Time of Death
	Physicia /Medic	al .	Philip Minor Davi	dson						Month lay	15 2004	1:30 a M
	Examin	er	4a. Facility Name (If not institution, give					Town, or Location of	of Death		4c. County of D	¥
			2127 Fountain Hil 5. Social Security Number 6. Se		e (In yrs. last b	irthdav)		imonium 1 Year   If Under	24 Hrs.   8	Date of Birth	Baltin	
	Funeral Director			JM 2015	52	Yrs.	Months	Days Hours	Min.	(Month, Day, )ct. 23	1951	Birthplace (State or Foreign Country)  Texas
	D .		Usual Residence of Decedent		1							
	anylar show	<u>.</u>	10a. State 10b. County		10c. City, To							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Pea-f	Director	MD Baltimor  10e. Street and Number	e	Т	imon	10f. Zip	Codo		11	0g. Citizen of What	
	with the or 3		2127 Fountain Hil	l Dv			101. Zip			"		Country :
	ns 23	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Vas Deced	21093 ent of Hispanic Ori fly Cuban, Mexican	gin? (Specif	y Yes or No-		merican Indian,
36	172 hours after death with the Maryland "natural", or Items 23s or 28s-1 show raical Exa⊤irer must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏠 Divorced	Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates:			fYes,speci I⊡Yes 2	_	i, Puerto Rio	an, etc.)	Black, W Specify:	hite, etc. white
Š	0 65 0	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16	a. Deced	lent's Usua	l Occupation	t of working		16b. Kind of Busine	ss/Industry
215	.는 . 근 폭티	npie	Elementary/Secondary (0-12)	College (1-4or !		life. L	DO NOT us	e retired)				
2	70 5 5		12	5+	Pr	rofes	ssor o	of Develo			Educa	ition
Maryland 21215-0036	be d la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Last)  Minor Davidson		13	y Ci ic	лоду		•		Boydstun	
ary	d 2 shoutd th and Men 7 Is marke traumatic	V a	19a. Informant's Name/Relationship (T	ype, Print)	19	b. Mailir	g Address	(Street and Number	er or Rural F	Route Number,	City or Town, State	a, Zip Code)
	and 2 lealth in 27 I		Mr. Minor Davids	on/son							nium, MD	
ore	of H of H if ite	J 8	20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ I	Removal from State		ery, cren	natory`or ot	her place)	Dat		20c. Location - City	
Ë	Pages Iment of tent: If it jury or o		'4 □Denation 5 □ Other (Specify	h -	Dulan					dens 5	/17/04	Timonium, MD
Baltimore,	permit. Pag Department Importent: I any injury o		Bryan W. Cla	lary			emmo	Address of Facili n Funera um, MD	al Hon	ne of D	Oulaney V	alley, Inc.
			23a. Part1. Enter * e disease, or comp shock, or heart fillure. List only of	lications that caused ne cause on each li	the death. Do					espiratory arre	est,	Approximate Interval Between
	Pnysician	8	Immediate Cause (Fi all disease or contition	Atteno	adeah	اد د	conchi	oveneula	1 do	وهمر		Onset and Death
	/Medical Examiner		resulting in death?	Due to (or as	a consequence	e of):						
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	e of):						
	ited Insit	Examiner	Cause (Disease or injury			/-						
Ć.	be executed sician and burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequence	e of):						
876	cate be ohysicia the bur	dical		d								<u></u>
89	ng ph	Med	IF FEMALE:							0.00		
Box 6	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal dea		Ectopic pre				23d. Date of Month	delivery Day Year
0.	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death	5 [	Other (spe	ecify)				,
٩	that the		Part II. Other significant conditions co	ntributing to death b	out not resulting	in the u	nderlying ca	ause given in Part I		23e. Did tob	pacco use contribute	to the cause of death?
ds,	uires sign ld be	d by	Chrenic dipres	sun						1 □ Ye	es 2. No 3⊡	Probably 4 Dunknown
of Vital Records,	w requir s been si should	Completed								24a. Was a	n 24b. Were	autopsy findings available
Re	The lav	mo						-		autops perform	ged? death	to completion of cause of ? 'es 2 No
ta		0	25. Was case referred to medical					26. Place	of Death (	Check only on		
₹ V	di S	To B	examiner? 1  Yes 2  No	Hospital: 1 🗌 Inpatio	ent 2 ER/C	Dutpatier	it 3□ DO	A Other: 4 ☐ Nu	rsing Home	5 Reside	ence 6 Other (S	pecify)
0 0	ng Ph fter th meral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	lry 28b	. Time of Injury		8c. Injury at Work?		d. Describe ho	w injury occurred	
Sio	tendi leath. lor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М	1 Yes 2		( ) 1 /0		Desir Control March
Division	ol or Attending F s after death. I Director: After d in by the funera	Certification;	4 Homicide determined	28e. Place of In building, et	tc. (Specify)	rarm, str	eet, factory	, опісе	28	City or Town	reet and Number of n, State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C		ysician: To the best iner: On the basis of and manner st	of examination a							
	To the To the Complex	Me	29b. Signature and title of certifier	Inco				License number	3 2	25	9d. Date signed (Mo	2004
•	П		30. Name and address of person who of	completed cause of	death (Item 23a	(Type				•	1	·
	. /		John O'Donovan,					k Ave	Raltin	more A	MD 21222	
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature				.vaitii		¥1111	
	Registi	rar	MAY 1	3 2004	Exercise.	S. S.	Speak	W				

		1	For State Registrar	State of	Maryland / Depa <i>Ce</i>	artment of H		Re	g. No. 2 ()	04	15738
	Division	_	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	Day	Year	3. Time of Death
	Physicia /Medic		Esther M.	East				May 13,			2:45 p M
	Examin		4a. Facility Name (If not institution, given	e street and numb	oer)	4b. City, Town, or	Location of Death		4c. County		
			8820 Walther Blv			Parkv			Balt	imore	
	uneral irector		213-03-3471	Sex 7. 1□M 2 <b>X</b> F	Age (In yrs. last birthday)  86  Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 5,	<sup>Year)</sup> 1917	Count	ace (State or Foreign try) <b>yland</b>
and	3	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				11	Od. fnside City Limits
faryli	sho	5	N. 1 . 1 D-14.		Don	kville					1 □ Yes 2 😿 No
the A	28a-	Directo	Maryland Baltin  10e. Street and Number	ore	Fai	10f. Zip Code		1	Og. Citizen of \	What Coun	try?
With	Sa or		8820 Walther Blv	, A		2123	34		II	SA	
Jeath	ns 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Rac	ce - America	
ter o	at i		1 Never Married 2 Married	Armed Force 1 Tyes 2 If Yes, Give	No	If Yes, specify Cuba		Hicen, etc.)		ck, White, e	
d 21215-0036 filed within 72 hours after death with the Maryland	E E	þ	3 XWidowed 4 ☐ Divorced	Year or Date	es:	1 ☐ Yes 2 🙀 No	Specify:		Specif	y: Wh	ite
2 2 S	lical	ted	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	king	16b. Kind of B	usiness/Ind	lustry
this of	. We .	ם	Elementary/Secondary (0-12)	College (1-4	for 5+)	DO NOT use retired	0				
2 Pg (2)	ygien t. E. th	Completed	12		E	lomemaker	40 14-15-1-1-1-1	ne (First, Middle, M		n Home	e
Maryland 21215-0036 nd 2 should be filed within 72 hours af	hygiene, dother then "natural", or liems 23a or 28a-f show event, tra Medical Exam ar must be notified at	Be	17. Father's Name (First, Middle, Las				•	_ ` ` ` ` `		_	
	and Mental Is marked of raumatic eve	ည		fler				Laura		uck	0-1-1
2 sh	ls m raum		19a. Informant's Name/Relationship			ing Address (Street				, State, Zip	Code)
and and	I Health and Menitem 27 Is marke other traumatic		Mr. Edgar E. Eas	t, Jr./	Son 27 C	october La	ine,Stow,		20c. Location	- City or To	wn State
Ore less 1	0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [	☐Removal from SI	tate cemetery, cre	matory or other plac				·	
E a	tant: jury		'4 □Denation 5 □ Other (Spec	A -	Parkwood			7/04	Baltin	nore,	Maryland
Baltimore,	Department of Healt Important: If Item 2 any injury or other once.		Bryan W. Cla	Ly	L 1	2. Name and Addre emmon Fun O W. Pado	eral Home nia Road	<u>, Timonii</u>	ım, MD	11ey 2109	Inc.
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that car y one cause on ea	used the death. Do not en ch line.	ter the mode of dyin	ig, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
Pin	ysician		Immediate Cause Final disease or condition	ader	occurcinon	na ute	آت کی	the met	asteuses h	luxx	Onset and Death
//	Medical		resulting in death)		r as a consequence of):						- N
Ex	aminer		Sequentially list conditions,	b							
7 0	=	ner	if any leading to immediate cause. Enter Underlying	Due to (o	r as a consequence of):	onsequence of):					
cute	ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C							
8760, ate be executed	hysician and the burial-transit	Ë	resulting in death) Last	Due to (o	r as a consequence of):						
	hysic the b	dlcal		d.	_					-	
ဖ ≝ှု	ed by the attending p detached for use as	Med	IF FEMALE:	220 If year outo	ome of pregnancy				024 De	nto of dollars	
Box eath cer	or us	by Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	1 Live bir		☐Ectopic pregnancy ☐ Other (specify) _	1			ate of delive onth	Day Year
O. 함	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknov		Other (specify)					
<b>□</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ad by detac	P.	Part II. Other significant conditions	contributing to dea	ath but not resulting in the	underlying cause giv	en in Part f.	23e. Did to	pacco use con	tribute to th	ne cause of death?
ds,	Pe eg							1 🗆 Y	es 2□No	3 🗌 Prob	ably 4 Nhknown
Vital Record sicien: The law requir	should	Completed						24a. Was a	n 24h	Were auto	psy findings available
Rec	has ye 2	шb						autops	med?	prior to cor death?	mpletion of cause of
<b>a</b>	certificate ha rector, page								2 <b>X</b> No	1 Yes	2 <b>X</b> No
of Vita Physicien:	this certifica al director, p	Be	25. Was case referred to medical examiner?	Hospital:	patient 2 ER/Outpatie	ent 3 DOA Oth	205	ath <i>(Check only or</i> Iome 5 <b>X</b> Reside		har /Specif	14)
o ş	rthis raldi	. To	1 ☐ Yes 2 🗶 No 27. Manner of Death	28a. Date of	f Injury 28b, Time	of 28c. Injur	ry at	28d. Describe h			77
	h. Afte fune	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		n, Day Year) Injury	Wor M 1 □	rk? ]Yes 2∐No				
/ision Attending	deat ctor: y the	fica	3 Suicide 6 Could not	be 28e, Place	of Injury - At home, farm, s	treet, factory, office				ber or Rura	l Route Number,
= 5	를 는 C	Certification:	4 Homicide	- buildin	g, etc. (Specify)			City or Tow	i, Siale)		
Hospita	Pur Pur	edical C	(Check only 2 Medical Ex	aminer: On the ba:	best of my knowledge, dea sis of examination and/or i	ith occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and m ate and place,	anner as st	tated. the cause(s)
the	within 24 ho To the Fun completely	Med	one) 29b. Signature and title of certifier	and mann	or states.	29c. Licens	se number	2	9d. Date signe	ed (Month,	Day, Year)
۲	8 ₹ 8			nonic	= MD	DE	8646		Marz 1/	200/	4
•	1.		30. Name and address of person wh		1 7		0076		May 14,	, 2004	•
	V				Walther Blv		more. Ma	rvland	21234		
	Ç+	ate	Anna Monias, M. 31. Date filed (Month, Day, Year)					. J LUILL	-1437		
	Regist			8 2004	Destina II	Sporte	7				

			1- For Amend Item #10e State of Maryland Department For Registrar	artment of Health and Mental Hyg	iene eg. No. 2004   5739
	Physic		1. Decedent's Name (First, Middle, Last)  MYRTLE FRANKL	2. Date of Deat	Day Year 3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number) ROCK GLEN NURSING HOME	4b. City, Town, or Location of Death  RACTIMORE	4c. County of Death
24 240	Funeral Director		5. Social Security Number  219 - 50 - 5934 6. Sex 10 M 200 7. Age (In yrs. last birthday)  10 M 200 7 Score 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	r 28a-f show	or	Usuel Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo	ecation MDRC	10d. Inside City Limits 1 <b>K</b> yes 2 □ No
	with the I	Il Director	10e. Street and Number 803 N. Woodington Road		Og. Citizen of What Country?
9800	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinat must be notified at	d by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 5 No Specify:	14. Race - American Indian, Black, White, etc. Specify: BLACK
Maryland 21215-0036	within iene.	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired) T SECRETARY	16b. Kind of Business/Industry HOSP ITAL
rylanc	be d la b	To Be	CHARLES MCPHAUL	18. Mother's Name (First, Middle, M	LEAN
	ges 1 and 2 should t of Health and Mer If item 27 Is marks or other traumatic		19a. Informant's Name/Relationship (Type, Print)  CATHERINE OUTEN  19b. Mailin  20a. Method of Disposition  20b. Place of Dispo	ag Address (Street and Number or Rural Route Number,  AFAYETTE AVENUE ( sition (Name of Date)	CATONSVIUE MD
Baltimore,	permit. Pages Department of I Important: If its sny injury or o		1 ⊠Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  ARBUTU	8 MEMORIAL 05/2/2/04/1	BALTIMORE, MD
Bal	Deparement Deparement		21. Signature of Funeral Service Licent 22  22 22  23a. Pert1. Enter the disease, or complications that caused the death. Do not enter	Name and Address of Facility AUGHN C. GREENE FUN SIST BALTIMORE NATIONAL	LPIKE BALTO MD 21220
60,	/Medical examiner prize	I Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	CELL CARCINOM RIGHT LUNG	
P.O. Box 68760	death certificate e attending phys ed for use as the	Physiclan/Medical		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
	iaw requires that the de as been signed by the 3 2 should be detached		Part II. Other significent conditions contributing to death but not resulting in the un END STAGE RENAL DISE	ACE ALC	acco use contribute to the cause of death?
Vital Reco	The lavate has	Be Completed by	HEPATITIS C . ESSENT/AL H	TE MELLITUS  24a. Was an autopsy perform 1 YPER TENSION  26. Place of Death (Check only one)	prior to completion of cause of death?  BNo 1 □ Yes 2 □ No
Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific compistely filled in by the funeral director.	Certification: To	1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death 1 No Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	28c. Injury at Work?  M 1 Yes 2 No	v injury occurred set and Number or Rural Route Number.
	To the Hospital of within 24 hours af To the Funeral Dominion of the Funeral Dominion of the Funeral Dominion of the Funeral Dominion of the Funeral Dominion of the Funeral Published in the Published In the Pub	edical Ce	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death (Check only one)  1 Medicel Examiner: On the basis of examination and/or invarient and manner stated.	occurred at the time, date and place, and due to the cau estigation, in my opinion, death occurred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
	To the within: To the comple	Med	29b. Signature and title of certifier  Rawal & Pawl 110	29c. License number 29c	5-17-2004
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, F KOMAL K - DANG MD - 3455, Will		
	Sta Registr		31. Date filed (Month, Day, Year)  WHA1 1 8 2004 32. Spistrar's Signature	Spirital	2/22.7

			For State Registrar		artment of Health and I ertificate of Death		gienez 0 0 4	15740
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Eugene Ed	ward Flesher,	D.D.S.	2. Date of Dea Month	16, Zoo4	3. Time of Death  a.15 P. M
	Examin		4a. Facility Name (If not institution, give s 1802 Clermont	Court	4b. City, Town, or Location of Death  Lu the VIII  If Under 1 Year If Under 24 Hrs.	e	4c. County of Deeth	nore Co.
4	Funeral Director		5. Social Security Number 6. Set 187-05-7496 19 Usual Residence of Decedent	7. Age (In yrs. last birthday  Yrs.  Yrs.	Months Days Hours Min.	Jan Day	21,1919 P	nplece (State or Foreign untry)
	e Maryland Sa-f show	Director	1.11.	ore Co. Luthe	rville			10d. Inside City Limits 1 ☐ Yes 2 No
	s 23a or 21	erai Dire	1802 Clermont		10f. Zip Code 21093 Was Decedent of Hispanic Origin? (S		10g. Citizen of What Con	A.
920	hours after death with the Maryland tural: or Items 23a or 28a-f show all Examinat must be nutified at	by Funerai	1 Never Married Married 3 Widowed 4 Divorced	Amed Forces?  VAYES 2 No W. W.III.  If Yes, Give Year or Dates: K. Lan Con.	If Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White	
1215-0036	J within 72 hours jiene. ir than "natural" ina Missical Ex	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	reation 16a. Dec	edenl's Usual Occupation e kind of work done during most of wor DO NOT use retired) PN 1 ST	rking	16b. Kind of Business/1 Dentist	Industry
Maryland 21	be filed Ital Hygi od other svent.	To Be Co	17. Father's Name (First, Middle, Last)  Joseph H.	Flesher		me (First, Middle,	Maiden Sumame) Michaels	
, Mary	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty.) Mrs. Joyce R.	Flesher 1800	ing Address (Street and Number or Ru Clermont Co	ural Route Numbe	itherville,	MD. 21093
altimore	Page ment o ent: If ury or		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signature Funeral Service License	Evans Fun	eratory or other place)  Live Chappel Belay	May 18, 2004	20c. Location · City or 1	HILL MD.
Ba	permit. Departr Imports sny inj		Mon J	ications that caused the death. Do not en ne cause on each line.	2325 YOCK	e or respiratory are	monium,	MD. 21093 Approximate
>	Physician /Medical		shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Pleural ell	wism			Interval Between Onset and Death
				Due to (or as a consequence of)	3			
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. left val.  Due to (or as a consequence of):	ricular Gallure	1 :	( ) ( )	lye
760,	7	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. left val.  Due to (or as a consequence of):	ricular faulure nitral value a	hisone (	(calfication)	lye 10 grs
.O. Box 68760,	7		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3	Ficular failure  Mital Value a  Betopic pregnancy  Other (specify)	disone (	(calficator)  23d. Date of deline Month	
P.O. Box 68	7	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy  1  Live birth 2  Fetel death 3  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.		23d. Date of deli	very Day Year the cause of death?
P.O. Box 68	e law requires that the death certificate be executed has been signed by the attending physician and pe 2 should be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.		23d. Date of deliment Month  Display to the proof of the proof to the	the cause of death?  babbly 4 [Unknown]  topsy findings available completion of cause of
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did to 1	23d. Date of deliment Month  Displaced use contribute to an an symmetry 2 DNo 1 DYes are to death?  2 DNo 1 DYes	very Day Year the cause of death? bably 4  Unknown topsy findings available completion of cause of
of Vital Records, P.O. Box 68	ding Physician: The law requires that the death certificate be executed to this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burnat-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con Cerebro 4 Cere	Due to (or as a consequence of):  Due to	□Ectopic pregnancy □ Other (specify)  underlying cause given in Part I.  26. Place of December 3□ DOA  Other: 4□ Nursing F	23e. Did to  1	23d. Date of deliment Month  Displaced use contribute to an an symmetry 2 DNo 1 DYes are to death?  2 DNo 1 DYes	very Day Year the cause of death? bably 4  Unknown topsy findings available completion of cause of
Vital Records, P.O. Box 68	or Attending Physician: The law requires that the death certificate be executed for death.  Iter death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	□Ectopic pregnancy □ Other (specify)  underlying cause given in Part I.  26. Place of Decent 3□ DOA Other: 4□ Nursing For 28c. Injury at Work? M 1□ Yes 2□No treet, factory, office	23e. Did to  1	23d. Date of delimental Month  Dibacco use contribute lo  Yes 2 No 3 Production of the prior to compare to compare the prior to compare	very Day Year  the cause of death?  bably 4 Dunknown  topsy findings available completion of cause of 2 No
of Vital Records, P.O. Box 68	or Attending Physician: The law requires that the death certificate be executed for death.  Iter death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	DEctopic pregnancy Other (specify)  underlying cause given in Part I.  26. Place of Decent 3 DOA Other: 4 Nursing For 28c. Injury at Work? M 1 Yes 2 No treet, factory, office	23e. Did to 1 Yes  24a. Was a autop perfor 1 Yes  ath (Check only or  tome 52 Resid  28d. Describe h  28f. Location (5 City or Tow	23d. Date of deliment of the proof to the pr	the cause of death?  babably 4  Unknown  topsy findings available completion of cause of  2  No  ral Route Number,
of Vital Records, P.O. Box 68	trending Physician: The law requires that the death certificate be executed death.  ctor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	□ Ectopic pregnancy □ Other (specify)  underlying cause given in Part I.  26. Place of Decent 3□ DOA Other: 4□ Nursing For Section of Section	23e. Did to  1 Yes  24a. Was a autop perfor  1 Yes  ath (Check only or  28d. Describe h  28d. Describe h  28f. Location (Socity or Town  28f. Location (soc	23d. Date of deliment of Month  Disacco use contribute to deliment of the contribute to death?  24b. Were auted prior to contribute to death?  1	very Day Year  the cause of death?  bably 4 []Unknown  topsy findings available ompletion of cause of 2 [] No  bify)  ral Route Number,  stated.  to the cause(s)  0, Day, Year)
of Vital Records, P.O. Box 68	or Attending Physician: The law requires that the death certificate be executed for death.  Iter death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	□ Ectopic pregnancy □ Other (specify)  underlying cause given in Part I.  26. Place of Decent 3□ DOA Other: 4□ Nursing For Section of Section	23e. Did to  1 Yes  24a. Was a autop perfor  1 Yes  ath (Check only or  28d. Describe h  28d. Describe h  28f. Location (Socity or Town  28f. Location (soc	23d. Date of deliment of Month  Disacco use contribute to deliment of the contribute to death?  24b. Were auted prior to contribute to death?  1	very Day Year  the cause of death?  bably 4 []Unknown  topsy findings available ompletion of cause of 2 [] No  bify)  ral Route Number,  stated.  to the cause(s)  0, Day, Year)
of Vital Records, P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnat-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	Detectopic pregnancy Other (specify)  underlying cause given in Part I.  26. Place of Decent 3 DOA Other 4 Nursing For 28c. Injury at Work? M 1 Yes 2 No treet, factory, office  uth occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time investigation.	23e. Did to  1 Yes  24a. Was a autop perfor  1 Yes  ath (Check only or  28d. Describe h  28d. Describe h  28f. Location (Socity or Town  28f. Location (soc	23d. Date of deliment of Month  Disacco use contribute to deliment of the contribute to death?  24b. Were auted prior to contribute to death?  1	very Day Year  the cause of death?  bably 4 []Unknown  topsy findings available ompletion of cause of 2 [] No  bify)  ral Route Number,  stated.  to the cause(s)  0, Day, Year)

		1 - For State Registrar	State of Marylan	d / Depa	artment of H	ealth and M Death		ene 20	,	15741
Physici /Medio		Decedent's Name (First, Middle, Last,     PAUL DUANE F	REEMAN				2. Date of Death Month		Year 2004	3. Time of Death 6:10 PM
Examir Funeral	er	4a. Facility Name (If not institution, give  16 E. 82nd St.  5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	_	City  If Under 24 Hrs.  Hours Min.	8. Date of Birth		cester	e (State or Foreign
Director		220-62-3704  Usual Residence of Decedent  10a. State  10b. County	M 2□F 50	Yrs. y, Town or Lo		Tiours Willi.	8. Date of Birth (Month, Day, 10 / 22 / 1	953		MD Inside City Limits
he Maryla 8a-f sho	Director	MD Worcest		cean C			100	a Citizon of V		1 XYes 2 □ No
h with t		16 E. 82nd St.			2184	2	10	US		
is 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic svent, the Madical Expirition and buildlifted at	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ Yo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - American ck, White, etc. V: White	
thin 72 hc	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work ()	ing 10		usiness/Indus	
Inial yiallia 4.14.1.3-0000 nd 2 should be filed within 72 hours aff the and Mental Hygiene. 27 Is marked other than "natural", or traumatic avent, the Medical Exam	Be	12 17. Father's Name (First, Middle, Last)		Hosp	itality Sp	18. Mother's Nam	e (First, Middle, Ma		aurant	
VICELY ICE  12 Should  h and Men  7 Is marke  traumatic	To	Earl H. Freema			ng Address (Street	and Number or Rur				ode)
Pages 1 and nent of Health in the Maltin of Health in the Maltin in the		Earl Freeman  20a. Method of Disposition  X Burial 2 □ Cremation 3 □ F	removal from State	Place of Disposemetery, cre	6 Gibbons sition (Name of matory or other place	(0)	Date 20	Oc. Location -	21214 City or Town,	
Dallillole; permit. Pages 1 ar Department of Hea Importent: If item: any injury or other		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens			od Cemete Shame and Addres Leopa	es of Facility	kad <sup>In</sup> gal		Manyl	
Physician /Medical Examiner personal and physician and physician and physician and physician and physician are provided to the physician and physician are provided to the physician are p	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Coech od v  Due to (or as a consequence)  Due to (or as a consequence)	vence of):	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Ap	oproximate terval Between nset and Death  3 Man Illa
death certificate attending physical for use as the	Physiclan/Medical Ex	IE EEMALE:	Due to (or as a conseq d.  23c. If yes, outcome of pregna 1  Live birth 2  Feta 4  Pregnant at time of d	ancy	□Ectopic pregnancy □ Other ( <i>specify</i> )			23d. Dat	te of delivery onth Da	ıy Year
uires that signed b	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.				cause of death?  y 4 Unknown
The law requires that the are has been signed by the page 2 should be detached.	Completed						24a. Was an autopsy perform	ed?	Were autopsy prior to compli death? 1 ☐ Yes 2	r findings available letion of cause of
Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	O.C.	h (Check only one			
Phy r this aral d	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur	y at	ome 5 X Residen 28d. Describe how			
UNISION el or Attending s after death. el Director: Afte	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office		28f. Location (Stre City or Town,		er or Rural R	oute Number,
To the Hospitel or within 24 hours after To the Funerel Direction Completely filled in the Complete of the Com	Medical (		rsician: To the best of my kno iner: On the basis of examina and manner stated.							
To the within 2 To the complet	Me	29b. Signature and title of certifier	luz 10.		29c. Licens	14314		d. Date signed	d (Month, Day	y, Year)
5		PANPIT P. KLU	c 11 a	n 23a) (Type	Print) mut, Soh	ibay, Y	no. 218	0/		7,10
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Jut, Soh	10				

ORIGINAL

	State Registrar  Decedent's Name (First, Middle, 1)	Last)		Pertificate of	Dealli	2. Date of Dea	th	.004	3. Time of Death
ian	Lhawrence Louis					Month May	16 Day	2004	12:50 P M
cal ier	4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death	J	4c. C	ounty of Death	
	Hospice of the (			Linthi			An	ne Arui	
	5. Social Security Number 215-09-0406  Usual Residence of Decedent		9 (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 27,	1914	9. Birth Cou Mary	place (State or Foreign intry) yland
or	10a. State 10b. County MD Anne Ar	undel	10c. City, Town o						10d. Inside City Limits 1 ☐ Yes 2 ※No
Completed by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	intry?
3	708 Meadowbrook	Road		21061			USA		
	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	Race - Ameri Black, White	
	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			pecify: Wh	
	15. Decedent's (Specify only highest	grade completed)	(6	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	during most of work	ing	16b. Kind	of Business/Ir	ndustry
	Elementary/Secondary (0-12) 7	College (1-4or 5		intance	,		Fo	od Supp	ply
	17. Father's Name (First, Middle, La	ist)	'		18. Mother's Name	e (First, Middle,	Maiden S	итате)	
2	Howard Granger				Viola S	ackman			
	19a. Informant's Name/Relationship			failing Address (Street					
	Mrs. Barbara Br	ruce / Daugh		19 Terrace isposition (Name of	a my special contract	estminst Date		MD 2115 tion - City or T	
	1 ☐ Burial 2 X Cremation 3		cemetery,	crematory or other pla	May 1	8,		ensvill	
	* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie		Chesape	ake Cremat 22. Name and Addre					re, m
	M	/	.220	Singleton	31 5 3	Second A Home PA	Cle	n Burni	ie, MD 2106
cal Evaluated	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I am a clast cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence of)	sufficie a	ncy waiden.	+			Interval Batween Onset and Death
,	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc; 5 □ Other (specify) _	у		23	d. Date of deliv Month	rery Day Year
ò	Part II. Other significant condition	s contributing to death bu	ut not resulting in th	ne underlying cause giv	ven in Part I.		bacco use		the cause of death?
najaidillo						24a. Was a	ın	24b. Were auto	opsy findings available
		-				autops perfor	med?	prior to co death? 1 ☐ Yes	ompletion of cause of
ט	25. Was case referred to medical				26. Place of Deatl		2 <b>4</b> 0	1 103	20.100
IOU: IO E	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1  lnpatie 28a. Date of Injur (Month, Day	y 28b. Tim	ie of 28c. Injur	y at	me 5 Reside		Other (Special	MHOSPICE
Certification	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be One Disea of Inju		, street, factory, office		28f. Location (S. City or Town		Vumber or Run	al Route Number,
Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of and manger sta	examination and/o	leath occurred at the tier investigation, in my d	me, date and place, opinion, death occurr	and due to the c red at the time, d	ause(s) ar ate and p	nd manner as s lace, and due t	stated. o the cause(s)
Me	29b. Signature and title of cestifier	4		29c. Licens	se number	2	9d. Date	signed (Month,	Day, Year)
	· - //			72	5645		5-	17-14	į.
	30. Name and address of person when the second seco	no completed cause of de	eath (Item 23a) (Ty	rpe, Print)	min X.	Share.	#61	JB.	MDDIOG

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

		For State of Mar State Registrar	•	rtificate of		Re	g. No. 2 (	004	1574
Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
/Medic	al	John M. Gamble  4a. Facility Name (If not institution, give street and number)		4b City Town, or	Location of Death	HAT	1	y of Death	18 19 183
Examin	er	ST. ACINES HEAL	HICARE		-Timor	6			
Funeral		5. Social Security Number 6. Sex 7. Age (	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 23,	Year) 1021	9. Birthp	place (State or Foreigntry) nsylvania
Director		Usual Residence of Decedent	02			Dec 25,	1921		
farylan show	ō	10a. State 10b. County MD	Oc. City, Town or Le Baltime						1 1 Yes 2 N
n the N r 28a-	Irect	10e. Street and Number		10f. Zip Code		10	Og. Citizen of	What Cou	ntry?
ath wit	rai D	919 DeSoto Road	110	212			USA	ice - Americ	can Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Heatth and Mental Hygiene. Important: If item 27 la marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, it a Medical Eventral research follows.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Every Amped Forces?  1 12 Yes 2 No If Yes, Give	WWII	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No		Rican, etc.)		ack, White,	etc.
72 hou natura lical E		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of I	Business/In	dustry
within ane. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+	) [	<i>DO NOT u</i> se retired arehouse	d)		Westi	nghou	.se
d be filed ental Hygie ked other c evant, t	To Be Co	17. Father's Name (First, Middle, Last)  John Milton Gamble			18. Mother's Nam Minnie				
d 2 shoul th and M 7 la marl traumati	T	19a. Informant's Name/Relationship (Type, Print) Annette Marsiglia/daughter		ing Address (Street				n, State, Zip	
s 1 and I Healt item 2 other		20a. Method of Disposition	20b. Place of Disp		1	-	20c. Location		
Pages ment of ant: If ury or		1 □ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 Bother (Specify) in state							
permit. Pages 1 and 2 should be filed within 72 hours alt Dep riment of Health and Mental Hygiene. Important: If tiem 27 Ia marked othar than "natural", or any injury or othar traumatic evant, it. Medical Evantons.		21. Signature of Euneral Service Licensee Ronal S. Wade Wade		2 Name and Addre tare Anat altimore,			Baltin	nore S	Street
		23a. Part   Enter the disease, or complications that caused to shock or heart failure. List only one cause on each line Immediate Cause (Final	he death. Do not er	iter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a	CANDIA	TEATR	INIGIO	- 1		1	
Examiner			CAN'DI A	11	4AMCI	1017			- 2day
rhed insit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence ory.						
be executed ician and burial-transif	Exa	resulting in death) Last	consequence of):						
ate be hysici the bu	dical	d.						-	
eath certificate be executed attending physician and for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 □ Live birth 2	f pregnancy	□Ectopic pregnanc	y			ate of deliv	ery Day Year
requires that the death een signed by the atter hould be detached for u	ysicia	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  4 ☐ Pregnant at ti 9 ☐ Unknown	me of death 5	Other (specify)				TOTAL T	Day Tour
es that the digned by the	y Ph	Part II. Other significant conditions contributing to death but	-	underlying cause giv	ren in Part I.	23e. Did tol	oacco use co	ntribute to 1	he cause of death?
w requires to been signer should be a	ted b	CORONARY ART	ERT	DISEAS	, <del></del>	1 🗆 Ye	s 2 No		bably 4 Unknov
The law ate has b page 2 sl	Completed by					24a. Was a autops perform	n 24b ned? 25 No	were auto prior to co death? 1 \( \text{Yes}	opsy findings availab impletion of cause of No
Phyaician: T this certificat ral director, p	Be	25. Was case referred to medical examiner?		Ott	26. Place of Dear				
ald this	1:10	1 Yes 2 No  27. Manner of Death  Natural 5 Pending (Month, Day)			ner: 4 ☐ Nursing Hory at	ome 5 ☐ Reside 28d. Describe ho			<i>fy)</i>
Attanding r death. ector: After by the fune	atior	2 Accident investigation	Year) Injury		rk?  Yes 2 □No				
To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (St City or Town	treet and Nun n, State)	nber or Rur	al Route Number,
Hospital or 24 hours afte Funeral Dir stely filled in	edical	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of and manner state	examination and/or i	ath occurred at the ti nvestigation, in my o	me, date and place, ppinion, death occur	, and due to the c rred at the time, d	ause(s) and r ate and place	manner as : e, and due i	stated. o the cause(s)
To the To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number	. 2	9d. Date sign	ned (Month,	Day, Year)
- >- 0		> Be le & mmce for Thomy	NB M	DP	16705	ſ	nAY,	61h,	2004
		30. Name and address of person who completed cause of de ANTHONY BAFFOF - BONNIE M	ath (Item 23a) (Type	AGNES	HEALTH	CARE,	BALTI	mone	imi)
7.00	ate	31. Date filed (Month, Day, Year) 32. Registra		land of					

			1 - State of Man		artment of Health and rtificate of Death	Reg.	ZUIII 15/10	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Allen P. Golden			2. Date of Death Month	Day Year 1940 PM	
	Examin	woman .	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Dea Baltimore		4c. County of Death	
H	Funeral Director		089-20-9424 ¹X™ 2□F	79 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) New York	
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 11  MD 15	Oc. City, Town or Lo			10d. Inside City Limits 1√√ Yes 2 ☐ No	_
	or 28s	Oirec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?	
0	after death w or Items 238	y Funeral Director	230 Stoney Run Lane #3A  11. Marital Status unk  1 Never Married 2 Married   12. Was Decedent Every Armed Forces?  1 Yes 2 No II Yes, Give Year or Dates:		21210 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel 1 Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White	_
200-612	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Maryland Examinating the modified at QDGs.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking unk	. Kind of Business/Industry	
yiariu z	ould be filed w Mental Hygie arked other t atic event, III	To Be Co	unk unk  17. Father's Name (First, Middle, Last)  Samuel Golden			me (First, Middle, Maid Bella Las	ker	
Z	nd 2 sho alth and 27 Is m ir traum		19a. Informant's Name/Relationship (Type, Print) Union Memorial Hospital		ng Address (Street and Number or Fi E.: University Pk			
oannore,	Pages 1 a nent of Hei ant: If Item ury or othe		20a, Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 20c	. Location - City or Town, State	
	permit. Deportr Imports any inj		21. Signature of Euneral Service Licensee Ronald S. Wade, Direct	tor est	2. Name and Address of Facility Cate Anatomy B Litimore, ND 212	d 655 W. Ba	altimore Street	
# 	Physician /Medical		23a. Part 1. Inter the disease, or com, lications that caused th shock, in heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death)	e death. Do not ent	ter the mode of dying, such as cardia		Approximate Interval Between Onset and Death	
	w requires that the death certificate be executed  been signed by the attending physician and measured by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions.	consequence of	Artery Dus	Ease	90 minu	k,
	the death certif the attending ched for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
cords, P.	requires that the een signed by th hould be detache	by	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?	
Hec	The lar ate has page 2	Completed				24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	_
> 5	Attending Physician: r death. sctor: After this certific by the funeral director.	ation: To Be	25. Was case referred to medical exampler?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 Accident Section 1 Pending (Month, Day Y	2 ER/Outpatier (ear) 28b. Time o Injury	nt 3 DOA Other: 4 Nursing	Home 5 Residence 28d. Describe how in		_
DIVIS	i gite	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (	- At home, farm, str (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)	_
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of representation of the basis of evaluation and manner states.	camination and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier	70	29c. License number	29d.	Date signed (Month, Day, Year)	
			30. Name and address of person who completed cause of deal	th (Item 23a) (Type,	Print) New H Pank	vay BeH	4 mare 120 21218	
ď	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 8 2004  32. Registrar's	Signature	South	1		

DHMH 17 Rev 1/2001

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2001

				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Ce	rtificate o	of Death	R	eg. No. 2	06 15745
	Physicia	n	Decedent's Name (First, Middle, Last)	GRUSMI	AN			2. Date of Dea Month	th Day	Year 3. Time of Death
- Line	/Medic	al	4a Facility Name (If not institution, give stri		,,,,		4b. City, Town, or	M / T	4c. County	204   - 17V
No.	Examin	er	JEN 11 STE CONTINUENCE	ESCIENT 1	and No	1 RSING H	ING 1	1KEVILLE	E A	TIMONE
	Funeral		5. Social Security Number 6. Sex	T. Age (In yrs. I		If Under 1/Ye		(Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		112 16 1105	1 2 COF 92	Yrs.			June 3,	1911	MASSACINSG
	and sand		Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	Mary B-1 sh	jó	MO BATTIN	Long	PI	LESVI	VIE			1  es 2 No
	th with the 23a or 28 and be not	Funeral Director	10e. Street and Number 7920 Scotts Lec	rel Ropp		10f. Zip Cod	1208	1	0g. Citizen of W	fhat Country?
21215-0020	filed within 72 hours efter death with tha Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Madical Examinat must be notified at	اڇ	11. Marital Status 12  1 X Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		a - American Indian, k, White, etc.
2-0	72 ho natur	eted	15. Decedent's Educat (Specify only highest grade of	ion completed)	(Give	dent's Usual Oc kind of work do	ne during most of wo	rking	16b. Kind of Bu	siness/Industry
121	within the transfer of the tra	Completed	Elementery/Secondary (0-12)	College (1-4or 5+) 2	life.	DO NOT use rei clerk			nha	ırmacv
d 2	filed withi Hygiene. other than	Be Co	17. Fether's Name (First, Middle, Last)		<u> </u>	CIEIR		me (First, Middle, i		
/lan	2 should be filed within and Mantal Hygiene. Is marked other than aumetic event, the Mannetic event, the M	To B	Morris Louis Grosm	an			Eli	zabeth Ra	fkin	
Maryland	2 sho and 1 is me		19a. Informant's Name/Relationship (Type Elaine Weinzweig/		1		eet and Number or R tone Road			
	1 and Health em 27 ther tr	,	20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of	, ,			City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. mportant: if item 27 is marked other than nny injury or other treumetic event, the Made.	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 🖾 Donation 5 ☐ Other (Specify)	noval from State	emetery, cre	matory or other	piace)			
Bal	permit. Pag Department important: I any injury o page.	1	21. Signature of suneral Service Licensee ROnald Wa	de Director		Name and Ad Late Ana Altimore			Baltimo	ore Street
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death cause on each line.	n. Do not en	ter the mode of	dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition	CANCO	SR	of	GLON			1 YGAR
	EXMITTED .	<u>.</u>	resulting in death)	Due to (o	r as a conse	quence of):				
	tificate be executed by physician and as the bunal-transit	Examiner	Sequentially list conditions, if any leading to immediate	Due to (o	r as a consec	quence of):				
68760,	be ex sician bunal		Sequentially list conditions, if eny, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated events	8 11/2						
687	ificate g phys as the	edical	resulting in death) Last	Due to (or	r as a consec	juence or):				1
Box	attending	an/M	d							
	as thet the death ce igned by the attendi be detached for uss	Physician/	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	nderlying cause	given in Part I.	23b. Did to	obacco use con	ntribute to the cause of death?
P.0	het the							1 □ Y	es 2 INO	3 Probably 4 Unknown
of Vital Records,	The law requires thet the death certificate be executed that been signed by the attending physician and paga 2 should be detached for usa as the bunal-transit	Completed by						24a. Wes a perfor	in autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
Rec	helaw hasl	dmo						101	00 2 GANO	1 ☐ Yes 2 ☐ No
tal	ician: The certificeta rector, pag	Be C	25. Was case referred to medical				26. Place of De	ath (Check only or		
Ž	Physician: rthis certific rtal director,	고	examiner?	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3LI DOA		Home 5 ☐ Resid	ence 6 □Othe	er (Specify)
o L	ng Ph fter th uneral	:io	27. Manner of Death 1 → Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njuryat Work? 1 □ Yes 2 □ No	28d. Describe h	ow injury occurr	ed
Division	To the Hospital or Attanding Physician: The Is within 24 hours aftar death.  To the Funeral Director: After this certificeta he completaly filled in by the funeral director, paga	edicai Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, st			28f. Location (S City or Tow		er or Rural Route Number,
Ö	s afta	Cert	4 Homicide	building, etc. '(Specif)	y) 			City of You	n, State)	
	To the Hospital within 24 hours To the Funeral completaly filled	cai	(Check only 2 Medical Examine	lan: To the best of my known: On the basis of examinat	wledge, deat tion end/or in	h occurred at the vestigation, in m	e time, date and plac ny opinion, death occ	e, and due to the curred at the time, d	ause(s) and ma late and place, a	nner as stated. and due to the cause(s)
	thin 2 the other	Med	one)  29b. Signature and title of certifie(	end manner stated.		29c. Lic	ense number	2	9d. Date signed	d (Month, Day, Year)
	F≯Fŏ		· 2 ×	and a	MA		DICIU	0	MAY	4.2004
			do mond and address of person	pleted cause of death (Item	n 23a) (Type,	Print)	- Hacitis	Av= .	6.h=	40 252
			31. Date filed (Month, Day, Year)	32. Registrer's Signa	fure (	2 MINNE	- ITLICITY	1115/	in with	11/11/15
	Sta Registr		MAY 1 8 2004	Genera E	de	route				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** 2:150 M 15 Annette E. Hallameyer /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 555 South MArlyn Ave. Baltimore Essex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 22, 1929 Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖫 F Maryland 74 214-24-3943 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ehow. "natural", or iteme 23a or 28a-f ehov 1 ☐ Yes 2X No Director Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 555 South Marlyn Ave. 21221 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **3, ∑**No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 31 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) own home Homemaker 7th other 7 is marked othe treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 20xe. Rose Cook Emil Blische 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 555 South MArlyn Ave. Baltimore MD Linda Blische/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/18/04 Baltimore MD Bayview Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 enn Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Dopper enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) month CARCINOMA **Physician** BRONCHOGENIC /Medical Due to (or as a consequence of) Examiner Socue field in the conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the Indeptying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 🔲 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 Inpatient 2 ER/Outpatrent Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. escribe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death in by the 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 8 2004

32. Registrar's Signature

Dhysiai	20	= For Unpend ITem#23a,27 Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De.	ath 🔭	Year	3. Time of Des
Physici /Medic				A. Hi	tch		MAY 10			12:23
Examin	er	4a. Facility Name (If not institution, give stre			4b. City, Town, o ROSEDAI		ath		ounty of Death	
		7614 PHILADELPHIA R 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birt	lb.	Q Birth	
Funeral Director			2⊠F 41		Months Days	Hours Mi	n. (Month, Da Nov. 19	y, Year) 196		place (State or Fo intry) vland
		Usual Residence of Decedent								
show	L	10a. State 10b. County	,	, Town or Lo		sedale				10d. fnside City L 1 ☐ Yes 2∑
8a-f	Director	MD Baltimor	е		10f. Zip Code	sedare		10a Citizer	n of What Cou	
e or 2	吉	10e. Street and Number 7614 Philadelp	hia Poad			1237		USA	11 01 <b>11</b> 111at 000	antry:
natural, or items 23e or 28a-f show	by Funerai		Was Decedent Ever in U.	S. 13. V			(Specify Yes or No erto Rican, etc.)		Race - Amer	
r iten	Fun	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No				erto Rican, etc.)	ł	Black, White	
Pai', o	by	3 ☐ Widowed 4 ☐ Pivorced	If Yes, Give Year or Dates:		I□Yes 21xxNo	Specify:		Sp	pecify.Whi	te
natu	Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a. Deced (Give	lent's Usual Occup kind of work done DO NOT use retire	nation during most of w	vorking	16b. Kind	of Business/I	ndustry
han han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		sabled	a)		Di	sable	d
Hygiene. ither than " ant, it e Me	ပိ	17. Father's Name (First, Middle, Last)	3yrs		Babica	18. Mother's N	ame (First, Middle,			<u> </u>
i Health and Mental Hygiene. item 27 is marked other than "natural", or items other treumatic event, it a Medical Examinat m	To Be	Edward Earl Ha	mmerbacker	-			ine V.Me			
mark mati	Ĕ	19a. Informant's Name/Relationship (Type,			g Address (Street		Rural Route Numbe			p Code)
alth ar 27 is r treu		Edward Hammerba	cker	16	525 Howa	ard Ave	e. Balti	more	MD 2	122
item othe		20a. Method of Disposition	., .,	emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Local	tion - City or T	own, State
int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 1 ☐ Donation 5 ☐ Other (Specify)	Ba	ayviev	v Crema	tory5/1	14/04	Balt	imore	MD
Department of Health a Importent: If item 27 is any injury or other tre once.		21. Signature of Funeral Service License		22	. Name and Addre	. (	Connelly	_		
		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one	tions that caused the deat	. Do not ent	er the mode of dying	ace AV	e. Balt: iac or respiratory a	LMOTE rrøst,	MD 2	Approximate Interval Between
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Medical xaminer		resulting in death)	Due to (or as a consequ							
Adminici	ايد	Sequentially list conditions, b	Due to (or as a consequ	uance of):					-	
nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 20 2 000004	201100 017.						
ysician and ne burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):						
ysiciai ne buri	cail	d								
		70.	_					-13		
affer death. Director: After this certificate has been signed by the attending phi in by the funeral director, page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant	. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	у		230	d. Date of delin	very Day Yea
the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)	·			WORT	ouy roa
ed by the detached		9 Unknown  Part II. Other significant conditions contri	buting to death but not resi	ulting in the u	nderlying cause an	ven in Part I	23e. Did t	obacco use	contribute to	the cause of deat
signed I be de	by	ratti. Ottor significant somations som	50 mg to down 50 mg to 100 mg		ndonying oddoo g		1 🗆 1	Yes 2□!	No 3□Pro	bably 4 <b>20</b> nk
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has ge 2	In In						autor perfo	ormed?	death?	opsy findings ava ompletion of caus
certificate ha	e Co	25. Was case referred to medical				OS Place of F	1 Yes Death (Check only of	2 No	1 Yes	2 No
is certific director.	To Be	avaminar?	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA Ott	200	Home 5 ☐ Resi		Other (Spec	ify) SCENE
eral d		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury			28d. Describe	how injury o	ccurred	"" SCENE
death. ctor: After y the funer	Certification:	1 □ Natural 5 □ Pending 2 ▼Accident investigation	5/10/04	12:23		Yes 2 No	Victim	of Hou	se Fire	
after de Directo d in by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and N wn, State)	Number or Rui	rai Route Number
rs aft al Di	Cer		Residence							osedale,M
100	edicai	(Check only 2 Medical Examine	ian: To the best of my kno r: On the basis of examina	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date and pla opinion, death o	ace, and due to the ocurred at the time,	cause(s) and pl	nd manner as ace, and due	stated. to the cause(s)
유교수	Medi	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date s	signed (Month	, Day, Year)
hin 24 h the Fur npletely	-	230. Signature and title of certifier	Grant 3		200. 20011	OCME			11, 20	
within 24 hours at To the Funeral D completely filled in										
within 24 h To the Fur completely		on New York C	pleted cause of death /h-	n 23a) (Tunn	Print)					
within 24 h To the Fur completely		30. Name and address of person who com			111 Pe	enn Stre	et, Balti	imore,	Maryl	and 2120

DHMH 17 Rev 1/2001

ORIGINAL.

			. For	State of Ma					•		•	
			1 - State Registrar				rtificate of			Rag. No	711114	15748
	Physici /Medic		1. Decedent's Name (First, Middle, La Donald	Joseph Hol	land,	, Sr.			2. Date of De Month MAY	ath 16		3. Time of Death 12:05 a M
	Examin		4a. Facility Name (If not institution, gi		1.6			or Location of Death		40	County of Death	
			40 Robin Hood  5. Social Security Number 6.			ıst birthday)	HAVI	e de Grac		th	Harfo 9. Birth	
	Funeral Director		194-03-4862 Usual Residence of Decedent	X M 2□F	88	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year		nplace <i>(State or Foreign</i> untry) nsylvania
	ryland how		10a. State 10b. County			Town or Lo			10.0			10d. Inside City Limits
	Ba-fs	cto	Maryland Harford		Hav	re de	Grace			0		1 ☐ Yes 3 No
	th with the	Funeral Director	10e. Street and Number 40 Robin Hood Ro	ad Box 746			10f. Zip Code 21078			USA	itizen of What Co	untry?
5-0036	I within 72 hours after death with the Maryland ilon. ilon. Itan. natural; or items 23a or 28a-f show the Medical Examinar must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Pican, etc.)	)-	14. Race - Amer Black, White Specify:	
ე ე	72 ho natur dical	eted	15. Decedent's E (Specify only highest gi	Education rade completed)		16a. Dece (Give	dent's Usual Occu- kind of work done	pation during most of wor d)	king	16b. h	(ind of Business/l	ndustry
7	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	Carpe		d)		Bu	ilding	
LZ D	Hyge Hyge		17. Father's Name (First, Middle, Las	t)		Carp		18. Mother's Nan	ne (First, Middle	}		
an	9 5 5 5	To Be	Wheatley Barnes	Holland				Josephi	ne Elde	r		
Maryland	P a a		19a. Informant's Name/Relationship					and Number or Ru		er, City	or Town, State, Z	ip Code) 2 <b>1</b> 078
	s 1 and 3 Health item 27 other tr		Hazel Marie Holl	and/Wife	20b. Pla			d Road Bo	x 746 }		e de Gra .ocation-City or 1	
2			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	Met	metery, crei	osition (Name of matory or other pla ematory	<sup>се)</sup>	8-04		timore,	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fune al Service Lice	man.	1	2	Name and Addre	ess of Facility	of MD.	Inc		
			23a. Part1. Enter the disease, or shock, or heart failure. List on	recorchik plications that caused	the death.			erick Koar ng, such as ardiac			re, Mb	21228 Approximate Interval Between
	Physician /Medical Examiner porusi-Iransil	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (y as a	con equi atr consequi	ence of):	rotect hugs wellit	oud us	Jasue	ule	) disi	Onset and Death
. Box 68760,	ath certificate ittending phys or use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a d.  23c. If yes, outcome c 1 Live birth 4 Pregnant at t	of pregnan	ncy death 3[	□Ectopic pregnanc	у		7 17 17	23d. Date of deli-	very Day Year
o.	res that the de signed by the a be detached f	hys	9 □ Unknown	9□ Unknown	Λ							
Vital Records, I	quires thi n signed ald be de	by	Part II. Other significant conditions	contributing to death bu	Tresul	Iting in the u	nderlying cause of	ven in Part I.		obacco Yes 2		the cause of death?
000	aw require is been sig 2 should b	Completed	pallua	kei					24a. Was		24b. Were aut	opsy findings available ompletion of cause of
ž	The law ate has page 2:	E O	V						perfo	2 N	death?	
lita I	cian: artific actor,	Be (	25. Was case referred to medical examiner?	Hanaital.			0.	26. Place of Dea	th (Check only o	one)		
0	Physi this c al dire	- T	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		R/Outpaties 28b. Time o	IL SELDOA		ome 5 K Resi		6 Other (Spec	ify)
O	Attending Physician: or death. actor: After this certifics by the funeral director. I	tion	1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day	Year)	Injury	Wo	rk? Yes 2 □No	200. 1 630106	now mije	ary occorred	
Division of	or Atten after dea: Diractor I in by the	Certification;	3 Suicide 6 Could not 4 Homicide determine	be One Blace of Injur	ry - At hor (Specify)	me, farm, st	reet, factory, office		28f. Location ( City or To	Street a wn, Stat	nd Number or Rui e)	ral Route Number,
-	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	edical C		Physician: To the best of and manner state	examinati							
	To the To the Comp	Me	29b. Signature and title of certifier	i 400.	W.	>	29c. Licen	se number 00/5/5	2	29d. Da	ate signed (Month	Day, Year)
	V		30. Name and address of person who		ath (Item		Print) ion Ave	nue Ha	avre de	e Gi	ace, M	D
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signati	ure						

DHMH 17 Rev 1/2001

MAY 1 8 2004 Service

ORIGINAL

				For State Registrar	State of Ma		epartment of li	Health and Me Death	ental Hygie Reg.	7004	15749
				Decedent's Name (First, Middle, Last	st)	-			2. Date of Death		3. Time of Death
_		Physicia		DOUGLAS	в. н	YATT			Month 1	Day Year	2:30 PM
		/Medic Examin		4a. Facility Name (If not institution, give		****	4b. City, Town,	or Location of Death	1 2 3	4c. County of Deat	'n
				North Dounded	Hospital		GlenBu	rnie.	(	Anne An	Labour
		Funeral		5. Social Security Number 6. S		e (In yrs. last birth	day) If Under 1 Year Months Days		B. Date of Birth (Month, Day, Ye	9. Birtl	nplace (State or Foreign untry)
		Director			<b>XX</b> 2□ F	47 Y	s.		08/27/1950	6 K/	ANŚAS
		pud *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
1		larylan ahow	ក		DUNDEL						1 ⊟Yes <b>XX</b> No
3		the M 28a-f notifie	Director	MARYLAND ANNE A  10e. Street and Number	RUNDEL	SEVE	RNA PARK		100	Citizen of What Co	untry?
Douglas		<b>€ ₽ 3</b>		531 PARK ROAD				146	log.	U.S./	•
2		ter death w	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.		Hispanic Origin? (Spec	ify Yes or No-	14. Race - Ame	
0		ter d	'n.	1 Never Married 20 Married	Armed Forces?		If Yes, specify Cul	oan, Mexican, Puerto R	ican, etc.)	Black, White	
	336	urs aft	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	`	1 ☐ Yes 2 <b>XX</b> No	Specify:		Specify: W	HITE
K.	0	72 hours "natural", Jical Ere	ted	15. Decedent's Ed		16a. [	ecedent's Usual Occu	pation	161	b. Kind of Business/l	Industry
13	215	hin 7 3. Me.ii	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or		ife. DO NOT use retire	during most of working ad)	7		
Hoof)	21	e filed with Il Hygiene. other ther	Completed	12	2		CARPENTER		NO	ORTH ARUNDEL	CONTRACTING
I	b	e file al Hy l othy vant	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, Maid	den Sumame)	
	/lai	uld b Mentz Irkad	70 E	BERNARD S. HYATT,	R.			FRANCES A	A. HERR		
	Maryland 21215-0036	s 1 and 2 should be f i Health and Mental H tam 27 ia markad ot othar traumatic eval	0	19a. Informant's Name/Relationship (	Type, Print)	19b. i	Mailing Address (Stree	t and Number or Rural	Route Number, Ci	ity or Town, State, 2	lip Code)
		and and all h	1	JANET M. HYATT				DRIVE, SEVERI	VA PARK, ME	21146	
	altimore,	of He of He fitan roth		20a. Method of Disposition 1     Transport Tr	Removal from State	anmatan/	Disposition (Name of crematory or other pla	Da	te 200	. Location - City or	Town, State
	Ĕ	Pages nent of I ant: If its ary or o		'4 □Donation 5 □ Other (Specify		GLEN H	AVEN MEMORIA	5/20/20	004 GL	EN BURNIE,	MD
	Balt	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra once.		21. Signal via of Funeral Service Licen			22. Name and Addr	ess of Facility F	INK FUNERAL EN BURNIE.	-	
		40		23a. Part 1. Enter the disease, or com shock, or heart railure. Dist only							Approximate
_		assawa.	8	shock, or heart failure. Dist only Immediate Cause (Final	one cause on each li	ne.	201	IEMORIZ	HALF		Interval Between Onset and Death
		Pnysician /Medical		disease or condition resulting in death)	a	a consequence of		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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			ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	):				
		sician and burial-transit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events	C					-	
	Ć.	exec n an	Exa	resulting in death) Last		a consequence of	):				
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	9	ificate g phys as the	edi						-	1	
	Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		• T =			23d. Date of deli	very
		death a atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at	2 ☐ Fetal death t time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	cy 		Month	Day Year
	P.O.	that the de ed by the a detached t	hys	9 Unknown	9□ Unknown				-		
		res that igned b	by P	Part II. Other significant conditions of	ontributing to death b	out not resulting in	he underlying cause g	iven in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
	rds	quire n sig ald bu	D D						1 ☐ Yes	212 No 3 □ Pro	bably 4 Unknown
	Vital Records,	w requires been si	Completed						24a. Was an	24b. Were au	topsy findings available
	Re	The lar	m						autopsy	1? death?	ompletion of cause of
	a	ician: Th	ပိ	25. Was case referred to medical				26. Place of Death	(Chack only one)	No 1 Yes	2 No
		aician: certific lirector,	0	examiner?	Hospital:	ent 2 ER/Out	eatient 3 DOA	hor		e 6 ☐Other (Spec	vi6.)
	of	Phys r this aral di	To To	27. Manner of Death	28a. Date of Inju	ury 28b. Ti	ne of 28c. Inju		d. Describe how in		ny)
15	Division	ding th.: After tuner	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ly Year) Inj		ork? ]Yes 2.∏No			
	2	Attandi er death. ector: A by the fu	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Ini	jury - At home, fam	n, street, factory, office	28		t and Number or Ru	ral Route Number,
	5	l or Att after d Direct I in by	erti	4 Homicide determined	building, et	c. (Specify)			City or Town, Si	tate)	
		To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier Certifying Ph	ysician: To the best	of my knowledge,	death occurred at the	time, date and place, ar	nd due to the cause	e(s) and manner as	stated.
		a Full letely	edical	Check only 2 Medical Exar	niner: On the basis o and manner st	of examination and	or investigation, in my	opinion, death occurred	d at the time, date	and place, and due	to the cause(s)
		Fo th within. Fo th xompl	Me	29b. Signature and title of certifier			29c. Licen	se number	29d.	Date signed (Month	, Day, Year)
		^		Dereke ka	s sa hun	MA	100	055973	M	Ay 16,	2004
(A)		18		30. Name and address of person who							
			-	ZELEKE DESSE				WAY SI	WER SPR	ING M.	D 20904
		Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signatyre	sparks				
	É	Regist	rar	MAY 1 8 2004	Denge	P	spouls				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND FIFM #17828a-b PER PHY G\*#! 2007 include of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May 14, 7:15 pm<sup>M</sup> 2004 Eleanor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Days Hours Months 7-18-7248 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylan 10a. State ral', or Itema 23e or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No MD Completed by Funeral Director KALTIMORE imonium 10g. Citizen of What Country? 10e. Street and Num 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates: it Sirou-in and Mental Hygiene.
27 Is marked other than "netural" "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 etari Maryland 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be GEORGE F. DUMPROFF ျ lizabeth 19a. Informant's ep e/Relationship (Type, P nt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Importent: If item 27 la any injury or other trau Hickory Meadow Kd CockeySVille Ma) 2.

2. Location - City or Town, State MD 21030 Method of Disposition

1 Burial 2 Cremation 3 R
4 Donation 6 Other (Specify) Baltimore, 20b. Place of Disposition (Name of cameters, guernatory on other place) ō Cremation 3 Removal from State Department 5-19-04 EVANS FUNERAL CHAPEC FOREST HILL MO ⁴ 4 □ Donation 22. Name and Address of Facility RD., TIMONIUM, MD 21093 PEACEFUL ALTERNATIVES FUNERAL CREMATION CENTER Approximate Interval Between Onset and Death 23a. Part1. Enter the dispase, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final bradyarrhythmia Physician disease or condition resulting in death) /Medical Examiner MYOCArdia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine 18 hours The law requires that the death certificate be executed that initiated events resulting in death) Last P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner?
1 XYes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28d. Describe how injury occurred 27. Manner of Death 5/1/2/6/4 ear) Natural 2 Accident investigation within 24 hours after death To tha Funarel Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7 (100) M. (1) M. (100) 4 Homicide 74 E. Padonia Kd., Apt. 202 home Less Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

hpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

(905ne11

8 2004

Control Cont				For State	State of Maryland / Dep	artment of Health and Martificate of Death		2001	15751
PROPERTY OF THE PROPERTY OF TH						Timeate of Beatif		10.C U U G	3. Time of Death
Second of Date   Control of		Physici	an	1. Social in Strains (1 mor, micros), Eddy			Month E	Day Yeer	
Consider Security Control Programme (Control Programme)  Control Interest Control Programme (Control Programme)  Control Interest Control Programme (Control Programme)  Control Interest Control Interest Control Programme (Control Programme)  Control Interest Co				4a Fecility Name (If not institution give		4b. City. Town, or Location of Death		tc. County of Death	7.60
Source   Discretion   Discret		Examir	er	4a. Pecinty Name (Il Not Il stitution, give	) is 5	Cally rown, or cocanor or beauti	(		OPE
Martin   Discount   Control   Cont				5 Social Security Number 6 Se	7 Age (In vrs. last birthday	If Under 1 Year   If Under 24 Hrs.	8 Date of Birth		
Usual Processors   100. Carry				The second second	M 2□E - V		(Month, Day, Yea	Coul	ntry)
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Type   Type		Man,	ţo	Daylon Batter	770 B 1900	2000			1 ☐ Yes 2X No
Type   Type		the 28a	rec	10e. Street and Number	CIVE BIANT		10g. (	Citizen of What Cour	ntry?
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Type   Type		leath ms 2:	era	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		
Type   Type	10	fter o	Ē		1≒QYes 2∏No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
Type   Type	33	Jrs a	þ		If Yes, Give	1 ☐ Yes 2 Mo Specify:		Specify: W	175
Type   Type	Ö	2 hou	ted			edent's Usual Occupation	. 16b.	Kind of Business/In	dustry
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22. Name and Address of Facility 22. Name and Address of Facility 23. Signature typeroff spring users as a consequence of program of the control of the cont		Hygoths snt,	a	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid		
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22. Name and Address of Facility 22. Name and Address of Facility 23. Signature typeroff spring users as a consequence of program of the control of the cont	Ž	od 2 lth a 27 ls		MANSIYNE H	58701. 450	2Kin. Au BE	TimoB	MARYI	400
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State  State  Shock of heart failure. List only one educe on each line.    Continued between a consequence of continued in mediate Cause (Final Immediate Cause				23a Part 1 Enter the disease of comp	lications that caused the death. Do not en	ster the mode of third such as cardiac	O 1 CORO I	HILLINI	A provimate
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Han D. Halle 4920 Campbell Word White Mand, MW 21236  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	5	after Dira	erti	4 Homicide	building, etc. (Specify)	,	City or Town, Sta	ite)	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Han D. Halle 4920 Campbell Word White Mand, MW 21236  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		o the ithin o the omple	Me			29c. License number	29d. [	ate signed (Month.	Day, Year)
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State		\		31 Date filed (Month Day Yours		regiment wind	10 mg	man jumes	در ک
				MAY 1 8 2004	berger B	books			

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	- 2		1. Decedent's Name (First, Middle, Last)	TIFM #20b PER FH G831 5/19/04 Offertificate of Death			Dealii	2. Date of Death 3, Time of Death			
100	Physicia /Medic		MINNIE	LEE	HIM	VES		Month	Day Year / 2, 2004	12:05 AM	
	Examin		4a. Facility Name (If not institution, give s	(If not institution, give street and number)  4b. City, Town, or Location of					4c. County of Death		
			UNION MEMOR  5. Social Security Number 6. Sex	. / /	SPITAL e (In yrs. last birthda	If Under 1 Year	8. Date of Birth				
	Funeral Director			M 2/X F	74 Yrs.	Months Days	Hours Min.	Month, Day, Ye	1929 50cm		
200	D		Usual Residence of Decedent					1100110		THE CHILDREN	
	show	5	10a. State 10b. County	10	10c. City, Town or	0	1 - 1 4 1 1	ne a	-11	10d. Inside City Limits  1 X Yes 2 No	
	28a-f	Director	10e. Steet and Number	114	l	10f. Zip Code	LTIMO	109.	Citizen of What Cou	intry?	
	h with		341 N. BRI	ICE S	TREET	-	212:	23	USA	,	
	r deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent of I	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,		
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or flems 23e or 28e-1 show event, the Medical Exatteria intellier indiffied a	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ Y If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🗖 No	Specify:		Specify:	nav	
21215-0036	72 hou natural		15. Decedent's Edu	cation	16a. De	cedent's Usual Occu	pation	168	o. Kind of Business/Ir	ndustry	
215	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life	ive kind of work done  DO NOT use retire	adring most or wor		2010 12.		
	filed with Hygiene ither the		17. Father's Name (First, Middle, Last)			USTOL	18 Mother's Nac	ne (First, Middle, Mai	340 RA	LROAD	
and	d be f antal h ced of	o Be	TAMES		HING	es.	F1;	A	11	SON	
Maryland	s 1 and 2 should be it Health and Mental Item 27 is marked oother traumatic eve	Lo	19a. Informant's Name/Relationship (Ty	pe, Print)			t and Number or Ru	ral Route Number, C			
-	1 and 2 Health a tem 27 ls		JAMES ROBERS	ON (50.		4/ N. B.	RUCE S	T. BALT	THORE, M	10.21223	
ore	8°= 5		20a. Method of Disposition  1. 8urial 2 Cremation 3 R	emoval from State	20b. Place of Dis cemetery, o	sposition (Name of crematory or other pla	5/18	/04	c. Location - City or To		
Baltimore	permit. Page Department Important: II any injury o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		MTZ	10N Em	ereu 65		- NSDOWN		
Ba	permit. F Departm Importar any injur		21. Signature of Furieral Service License	N.U.	llians	JOSEY	PHH	AVE. &	BALTO, 1	RAL HOME	
A STATE OF	21		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	d the death. Do not	enter the mode of dy	ng, such as cardiac	or respiratory arrest,	77(227017)	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		NEUM	ONIA				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
	F E D	ē		b. Due to (or as a sonesquenes of):							
	cuted nd ransit	Examiner	cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events	c							
ő,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):							
928	ate the	dical		l					-		
Box 6	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of deliv	ery	
	death e atte	icla	in the past 12 months? 1 □ Yes 2 □ No	1∐Live birth 4□Pregnant at 9□Unknown		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	:y		Month	Day Year	
P.0	that the de led by the detached	Physiclan/Med	9 Unknown				. 0	an- Didasha			
of Vital Records,	signed	Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ ☐ mknown		
	w requir been si should							24a. Was an	24b Were autr	opsy findings available	
Re	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as				-			autopsy performed 1 ☐ Yes 2 ☑	prior to co	ompletion of cause of	
ita			25. Was case referred to medical examiner?					th (Check only one)			
of V	Physicien: this certific ral director,	ပ	1 ☐ Yes 2 No	lospital: 1 Hopatie				ome 5 Residence		<i>(y)</i>	
	ling After une	Certification:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time Injur	y Wo	ryat ⊮k? ]Yes 2 □No	28d. Describe how i	njury occurred		
Division	or Atten after deat Director: in by the	ifica	3 Suicide 6 Could not be determined	8 29a Blood of Injury. At home form extent factors office.		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		Cert						City of Town, 3	ony or rown, statey		
	de tal	Medical			f examination and/or			, and due to the caus rred at the time, date			
	To the Hos within 24 hr To the Fun completely		COL Cine there are title of contifier			29c. Licen:	se number	29d.	Date signed (Month,	Day, Year)	
	n		> & mellen	nang	19-	D D.	47123	M	AY 12,	2004	
	17		30. Name and address of person who co	mpleted cause of c	death (Item 23a) (Typ	De, Print) VAU	ON ME	MORI AL	HOSPIT	-A-C	
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VMON MEMORIAL HOSPITAL  JOSEPH PUTHLINAMA 201-E. WIV. PKWY, ISALTIMORE MID 212(8)  31. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)  33. Registrar's Signature								
-8%	Registi		MAY 1 8 2004	Carla		D					
				1							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 15, Day 2004 Year **Physician** 11:30 рм Mary Kathleen Herfurth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Ridgeway Manor Nursing Home | Catomer 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1918 Catonsville 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2√2 F 85 217-03-9846 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Exercitive Exercitied at 1 Yes 2 No Md. Baltimore Catonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5743 Edmondson Ave. 21228 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: White Specify: Completed by 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. Schools Custodian 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any niury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Jarboe Charles Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5533 Emory Rd., Upperco, Md. 21155 Geraldine Martin - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery May 19,2004 Baltimore, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 21117 11605 Reisterstown Rd., Owings Mills, M d. C 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart beliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alxbeimer's **Physician** several /Medical years Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68768 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Is signed by It Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à , Cerebrulas cilas Disorder 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an certificate has 1 ☐ Yes 2 🕱 No Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐪 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō 1 Na Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29c. License number 29b. Signature and title of certifier 127541 Geether Rayorus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GETHA RAJAMD, 4367 Holling Flyng Beltimory, MD-21227 Rd 31. Date liled (Month, Day, Year) 1 8 2004

State Registrar

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			For Amend Item 24a per	State of	Mesyley	rel/dRepa Cei	artment of Hartificate of	lealth and <i>Death</i>		jiene eg. No.20	04	15755
	Physici		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Davh	Year	3. Time of Death
	/Medic	al	CHARLES		RIS	MO	4h Oh Tour	at antino of Dog	MBY	12 2 4c. County	ov to	6.55 M
	Examin	er	4a. Fecility Name (If not institution, give		iber)			or Location of Dea LSTOWN	ALTI	Í	TIMOR	RE CO
-	Funeral		NORTHWEST HOSPITAL  5. Social Security Number 6. Se	(	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr				lace (State or Foreign
	Director		221-38-1622	M 2□F	75	o Yrs.	Months Days	Hours Mil	JUNE 1			H CAROLINA
	and .	-	Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryl	į	MARYLAND N/A			F	BALTIMORE	1				1∑Yes 2□No
	r 28a	Director	10e. Street and Number				10f. Zip Code			l0g. Citizen of V	Vhat Coun	itry?
	23a o		1600 W MT ROYAI	L AVE.	APT 13	304	21	.217		U.S.	Α.	
	rdea	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13. \	Was Decedent of h	dispanic Origin? ( an, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		e - Americ k, White,	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 🔀 Yes If Yes, Give	2 □ No e <sup>ttes:</sup> 46/47	_	1 ☐ Yes 2 🖾 No	Specify:		Specify	BLAC	'K
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. diction than "naturel", or items 23a or 28a-f show dother than "naturel", or items 23a or 28a-f show event. I've Medical Examinar misal be notified at		15. Decedent's Edu	cation	46/4	16a. Deced	lent's Usual Occup	pation		16b. Kind of Bu		
215	within 72 ene. then "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-	4or 5+)	(Give	kind of work done DO NOT use retire	during most of w d)	orking			
21	e filed within al Hygiene. I other then ' vent, I're Mo	Con	llth grade	,		LABOR	RER			FACT		
Maryland		Be	17. Father's Name (First, Middle, Last)	AT.					ame (First, Middle,		10)	
Z	s 1 and 2 should be f I Health and Mental I Item 27 is marked of other traumatic eve	ို	ORANGE HARRISO			19b Mailir	ng Address /Street	•	NITA HARR Rural Route Numbe		State Zin	Code
Ma	D = 17 = 2		Mary Johnson/Dau	, . ,					rcle, Bal			
ē,	s 1 and 2 if Health item 27 i		20a. Method of Disposition	<del></del>		Place of Dispo	sition (Name of natory or other pla	1	Date	20c. Location -	-	
E	Page nent o int: If iry or		1 🔀 Burial 2 □ Cremation 3 □ F  `4 □ Donation 5 □ Other (Specify)	lemoval from S	tate	•	LLE VETER		17-04	CROWNSV	ILLE	MARYLAND
Baltimore,	permit. Pages 'Department of h Important: If ite any injury or ot once.		21. Signature of E	lolle	V	W.	Name and Addre	ess of Facility BROWN CORTH AVE	OMMUNITY NUE	FUNERAL	номі	E P.A.
	TIT		23a. Part L Enter the disease, or compl shock, or heart failure. List only or	ications that ca	used the deat	th. Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	<u> </u>	SPIRE	COLTE	i Pi	JEUMO	ALM			Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a conseq	quence of):	205.					
		er		Due to (	or as a conseq	uence of):	SEPS	15				
	uted d ansit	Examiner	if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events	3.								
0,	an an rial-tr		resulting in death) Last		or as a conseq	(uence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d							_	
9 ×	leath certific attending pl		IF FEMALE:	3c. If yes, out	come of preans	ancy				60.1.0		
Вох	attend for us	Physician/M	in the past 12 months?	1⊡Live bi	nth 2 ☐ Feta ant at time of d	al death 3	Ectopic pregnanc Other (specify) _	у		23d. Dat Moi	e of delive nth	Day Year
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ords	w require been sig should b								1 🗆 Y	es 2 🗆 No	3 🗀 Prob	ably 4 Unknown
Records,	has be	Completed							24a. Was a autops	sy p	prior to con	psy findings available inpletion of cause of
= H		Con							1 Yes	med? c	leath?	2 <b>.X</b> No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	4. 11.			200	eath (Check only or			
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on	Attending I or death. ector: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigation	(Monti	n, Day Year)	Injury	Wo	rk?  Yes 2∐No				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined		of Injury - At h ig, etc. <i>(Specil</i>		eet, factory, office		28f. Location (S. City or Town		er or Rura	l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edlcal C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the ner: On the ba and mann	sis of examina	owledge, death ation and/or in	occurred at the tr vestigation, in my	me, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
	To the To the	Me	29b. Signature and title of certifier	.^	v 1:		29c. Licens	se number	2	9d. Date signed	(Month, I	Day, Year)
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	Sta Regist	_	31. Date file MADYh, Pay 8 ea 1004	13724	gistrar s Signa		-1					

			1 - For State Registrar	State of Maryl		artment of H			iene 9. No. 20	04 15756
	Physicia	an	1. Decedent's Name (First, Middle, Last)	SNYATINS	シアし			2. Date of Deat Month	h Day	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s			4b. City, Town, or	t ocation of Dea	may	Day 15 20	004 10.35AM
	Examin	er	NORTHWEST HOSPITAL			RANDALL		2011	BALTI	
	Funeral Director		5. Social Security Number 6. Sex 215-54-3626	7. Age (In )	vrs. last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hi		1911	9. Birthplace (State or Foreign ROMANIA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limits
	Marylan a-f show	tor	MD N/A		BALT	IMORE				1 TYYes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code	01015	1	0g. Citizen of W	•
	eath w	eral	7008 BOXFORD ROAD	) 12. Was Decedent Ever i	nUS 13	Was Decedent of Hi	21215	(Specify Yes or No-	14. Race	U.S.A.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Franizer must be rediffed at	ğ	1 ☐ Never Married 2 🏋 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	(Specify Yes or No- erto Rican, etc.)		k, White, etc.
2-0	"natur	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of w	rorking	16b. Kind of Bu	siness/Industry
121	filed within Hygiene. other than ent, the Me	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	TAIL		"		GARMEN <sup>2</sup>	Г
nd	al Hyg al Hyg d other	BeC	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	Maiden Surnam	
yla	2 should be and Mental is marked of sumatic eve	<sup>L</sup>	CHANONN	an Drine)		TINSZKI	FRY		City of Town	(UNKNOWN)
Mai	and 2 st ealth and n 27 is n		19a. Informant's Name/Relationship (Ty) IDA IAGNYATINSZKI		1	-		Rural Route Number, BALTIMORI	-	
ore,	of Health itam 27		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	20		sition (Name of matory or other plac				City or Town, State
Baltimore,	Page Iment tant: if		' 4 ☐ Donation 5 ☐ Other (Specify)	emovar nom state	HEVRA A	HAVAS CHE	SED 5/			LSTOWN, MD
Ball	permit. Pages. Department of Himportant: If its any injury or ot once.		21. Signature of Funeral Service Licenson		8	900 REIST	ERSTOWN		KESVILI	LE, MD 21208
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		_	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ue to (or as a con	sequence of):	1				DAYS
	Examiner		Sequentially list conditions	)						
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (clisses) or injury	Due to (or as a con	sequence of):					
Ć,	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
120	cate be ohysicie the bur	cal		I						
x 68	eath certifica attending ph for use as th	Med	IF FEMALE:	20 If you gutgame of arr						
P.O. Box	the the	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery hth Day Year
	es that thigned by	y Ph	Part II. Other significant conditions cor	=				23e. Did tob	acco use contri	bute to the cause of death?
ord	w require been sig should b	ted t		ELLITUS,				1 □ Ye	s 2 000	3 Probably 4 Unknown
Il Records,	ysician: The lawr is certificate has be director, page 2 sh	Completed	DENIENTIA.	CORUNA	ny As	CTERY D	) IS GALE	24a. Was al autops perform 1 Yes 2	y p ned? d	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2☐ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Other	oe.	eath (Check only on		
of	iding Phys th. : After this funeral di	ıtlon: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	f 28c. Injun Worl	4   Nursing	Home 5 Reside		*****
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st pecify)	reet, factory, office		28f. Location (Sti City or Town		er or Rural Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical (	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exemination	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, deat nination and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	use(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	yes me	)	29c. License	e number	29	Od. Date signed	(Month, Day, Year)
	Y		20 None and address of account	V / (1)	(Itom 23a) (Tues	Print)	7 7 0 0		Dr vily	14 0009
	0		30. Name and address of person who co	Kamor	vary	North	est H	ospitel	med	14th 2004
	Sta Registr		31. Date filed (Month MAY 1 8 2	2004 32. Registrar's S		Spar	K			

				For State Registrer	•	Certificate of Deati			10/0/
				Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
_		Physici /Medic		Kuth Marc	Jenkin	15	Month	12 2004	1 12:30 A.M
		Examin		4a. Facility Name (If not institution, give street		4b. City, Town, or Location	n of Death	4c. County of Deat	
				Stella Maris	Hospice	Timonio	m	BALTI	MORE
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	hday) If Under 1 Year If Under 1 Months Days Hours		ay, Year)	untry)
		Director		Usual Residence of Decedent	8.1	13.	7-13	5-16 11/a	ryland.
		yland sow		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
		Mar Mar	tor	MD BALTIMO	RE T	ARKVILLE			1 Tyes 2 No
		th the	Direc	10e. Street and Number	1 -	10f. Zip Code		10g. Citizen of What Co	untry?
		death with the Maryland ims 23a or 28a-f show Ir must be notified at	rai	8313 NUNley I	SR. Apt. H	212		USA	
		er de (	Funeral Director	11. Marital Status	as Decedent Ever in U.S. med Forces?	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No an, Puerto Rican, etc.)	14. Race - Ame Black, White	
Ė	36	rs aft	by F	1 Never Married 2 Married 1  1 Widowed 4 Divorced Y	med Forces?  Yes 2 No Yes, Give ear or Dates:	1 ☐ Yes 2 No Specif	y:	Specify: /k)	hite.
ਰ	21215-0036	172 hours after death with the Marylar "natural", or Items 23s or 28s-f show calcal Exeminer must be notified at	Be Completed by	15. Decedent's Education (Specify only highest grade com	16a	Decedent's Usual Occupation		16b. Kind of Business/	Industry
:30	215	thin 7 e. an "n	nple		ollege (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired)	ost of working	~ 0	
12:	2	filed within Hygiene. Ither than "	Con	12	K	ate Clerk		B+ORa	ilroad
_	Maryland	should be filed withir and Mental Hygiene. is marked other than aumatic event, Ite M.	Be	17. Father's Name (First, Middle, Last)			her's Name (First, Middle	, Maiden Sumame)	
4	<u>~</u>	should nd Mer marke imatic	ဥ	19a. Informant's N. e/Relationship (Type, P	rint) 19h	Mailing Address (Street and Num	lances U	er City or Town State 2	in Code)
2004	Ma	d 2 s th an t7 is r		Sharon Czaikou		0.0	DR. ADT. F.	Papyville	MD 21234
•	ည်	ss 1 and 2 of Health item 27 i		20a. Mpthod of Disposition	20b. Place of	Disposition (Name of v, crematory or other place)	Date	20c. Location - City or	
12	altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Ptygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, If a Modical Examinating must be notified at once.		1  Burial 2  Cremation 3  Remov 1  Donation 5  Other (Specify)	ral from State	Man Pack	5-14-04	PARKVille	nin
MAY	alti	mit.   partm portal		21. Signature of Funeral Service Licensee	Tor era	22. Name and Address of Fac	BALTIMER	E, mD 212	24
Σ	m	Deparement Deparement		Kimberly (1).	awioter	EVANS FUNERA	K CHAPEL	_ 8800 HA	REPORD RA
				23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death. Do nuse on each line.	ot enter the mode of dying, such a	as cardiac or respiratory a	rrest,	Approximate Interval Between
		Priysician		Immediate Cause (Final disease or condition	CEREBROVASCULAI	R ACCIDENT			Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a consequence of	f):			
			<u></u>	Sequentially list conditions, b.	Due to (or as a consequence of	t)·			
		ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events c	200 10 (01 40 4 201304401100 0	,,,			
	Ć,	execunand and ial-tra	Examiner	resulting in death) Last	Due to (or as a consequence of	f);			
	68760,	tificate be executed ig physician and as the burial-transit	edicai	d					<del>-</del>
				IE EENMALE.					
	Вох	eath cert attending	an/h		yes, outcome of pregnancy □Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deli	very Day Year
W	D. E	The law requires that the death cer Ite has been signed by the attendir vage 2 should be detached for use	by Physician/M	1 Vac 2 Vac	□Pregnant at time of death □Unknown	5 Other (specify)		World	Day Todi
×	Ρ.	hat th ad by detacl	Ph	Part II. Other significant conditions contribut	ting to death but not resulting in	the underlying cause given in Par	t I. 23e. Did t	tobacco use contribute to	the cause of death?
	ds,	uires tha signed d be det			<b>,</b>	,g g		Yes 2□No 3□Pro	
S	Records,	w require been si should l	Completed				24a. Was		topsy findings available
JENKINS	Re	The lav	dmc				auto	psy prior to o ormed? death?	completion of cause of
E	Vital		Be Co	25. Was case referred to medical		26. Pla	1 ☐ Yes		2□ No
	Ž	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 X No Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Out	Other	1	dence 6 NOther (Spec	ify) HOSPICE
RUTH	n of	ding Physician: The After this certific funeral director.	:uo	27. Manner of Death 1 Natural 5 Pending	a. Date of Injury 28b. T (Month, Day Year) In	jury Work?		how injury occurred	
<u> </u>	Sio		catio	2 Accident investigation		M 1 □ Yes 2[			
	Division	or Attendate deat Director:	Certification:	4 Homicide determined 28	<ul> <li>Place of Injury - At home, far building, etc. (Specify)</li> </ul>	m, street, factory, office		Street and Number or Ru wn, State)	ral Route Number,
		pital ours a eral (		29a. Certifier 1X Certifying Physicier	* To the hest of my knowledge	death occurred at the time, date	and place, and due to the	cause(s) and manner as	etated
		To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examiner: (		for investigation, in my opinion, de			
_		To the within To the compl	Me	29b. Signature and title of certifier		29c. License number	r	29d. Date signed (Month	Day, Year)
				1-1-1		D437	25	5/12/	04
_		X		30. Name and address of person who comple	ted cause of death (Item 23a) (	Type, Print)			
				DR. TARIQ MAHMOOL	T	VALLEY RD. T	IMONIUM, MD	21093	
		Sta Regist		31. Date filed (Month, Day, Year) MAY 1 8 2004	3. Registrar's Signature	poorked			

		1	For Amend Item 7,8 p	eState of Masy	and ARepa	artment of H	lealth and	Mental Hy	giene 2	2004	15758
			Registrar  1. Decedent's Name (First, Middle, Last,	)				2. Date of De	aath		3. Time of Death
	Physicia		ANNIE	L.	Jones			Month Month	Day	Year 200 4	8:30 AM
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Deat	th	4c. Co	ounty of Death	
۱			BON SEWYRS	HUSP, 80	<u></u>	Ballin	white CI	144	01/16	/01	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In 83	yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. (Month, D.	ay, Year) 10	9. Birth	place (State or Foreign ntry)
	Director	}	230-22-7143 Usual Residence of Decedent	ω -σ				01	6 2	Z-	_VA
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ont, the Medical Examinar must be mutified at		10a. State 10b. County	100	. City, Town or Lo	ocation					10d. Inside City Limits
	Man,	iò	MD Baltin	nore	Randal	llstown					1 □ Yes ¾∏No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	10g. Citize	n of What Cou	ntry?
	23a	rai	3903 Noyes Circ			211		2 2 2		. S . A .	and lading
	er de	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	0- 14	Black, White	
36	be ilied within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or liems 23a or 28a-f show ovent, the Medical Examinat must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Si	pecify: B	Lack
9	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation	orkina	16b. Kind	of Business/Ir	ndustry
215	hin 7.	ple	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retired	d)	икиц			
2	ygiene er th	Completed	7th grade	na	Dor	nestic W				Prival	:e
Maryland 21215-0036	0 - 0 5	Be	17. Father's Name (First, Middle, Last)					me (First, Middle		umame)	
yla	should be ind Menta imarked imatic ev	ျှ	Roy Dillard		405 44-11	- Address (Ctroot		Freema		Tourn State 7	o Code)
Mar	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Nama/Relationship (T)		455000	ng Address (Street		1 200			21133
	s 1 and f Healt item 2	1 18	Daniel E. Johns 20a. Method of Disposition	son-Cousin	Ob. Place of Dispo	Noves	Circle	Apt 20	206. Loca	andal ition - City or T	own, State
Baltimore,	9 = 5	1	1 N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		•	matory or other place	1	E /10 /			** 3
Ħ	permit. Pa Departmen mportant: any Injury		21. Signature of Funeral Service Licens	n	2	Memoria 2. Name and Addre	ss of Facility	5/19/0	4 Ar	butus,	Ма
Ba	Depa Impo any le		Smelle	K. Jones	I L	March F/ 1300 Wab	т west bash Ave	e, Balt	imor	e Md	21215
	=		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		static	SAL	te of	2 446	(w)	10,0	Onset and Death
	/Medical		resulting in death)	Due to (or as a cor							
ı	Examiner		Sequentially list conditions,	b							
	of tis	in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence ot):						
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of):						
760,	le be e) ysician e buria	cal E		_							
687	<u>w</u> > w			d							
Box	leath certificate attending phy I for use as the	2	23b. Was decedent pregnant	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		□Ectopic pregnancy	v		23	d. Date of deliv	
	death	lcia	in the past 12 menths?	4 Pregnant at time		Other (specify)	<i>y</i>			Month	Day Year
P.0	The law requires that the death certifical ate has been signed by the attending phage 2 should be detached for use as th	Physician/Med	9 Unknown					an- Did	Ashaasa waa	a a a staib uta ta	the serves of death?
	es the	þ	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the t	underlying cause giv	ven in Paπ I.		Yes 2		the cause of death? bably 4 Hunknown
ord	w require been sig should b	Completed						-			
ec	e law has b je 2 st	npie						24a. Wa auto		prior to c death?	opsy findings available ompletion of cause of
Vital Records,	icate ha							1 ☐ Yes	2 🗆 🗥 6	1 🗆 Yes	2 No
V:E	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	at 30 004 Ott	0.00	eath <i>(Check only</i> Home 5 🗆 Res		Other (See	(6)
o	Phys r this sral di	-	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe			<i>y</i> /
on	ding Ph th. : After th s funeral	tlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		a <i>r)</i> Injury		rk? ]Yes 2 ☐ No				
Division	Attendir death	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, si	treet, factory, office			(Street and i	Number or Ru	al Route Number,
á	s afte	Certification;	4 Tiomicus	building, oto. (5							
	ospit hour unera		29a. Certifier 1 Certifying Ph	ysician: To the best of mainer: On the basis of exa	y knowledge, dea mination and/or i	th occurred at the ti	me, date and place	e, and due to the	e cause(s) a	nd manner as lace, and due	stated. to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one)	and manner stated.		29c. Licens				signed (Month	
	To To	2	29b. Signature and title of certifier	1 6-					130. Date	angried (Moriti)	2 (
	0-		Alber 100	w, MD	//		9771		179 y	14.	7004
	h		30. Name and address of person who	N/ID		(, Print)	ه در ما خلاه	Sheit	L B	1 1 2 14	E, Maylar
						(6. \ L				1 11/2 2	/ //A / A ! !
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	" 7	EST 30	TIOTINICE	-44 -6	4 64	1300	1 Mylau
	St: Regist	ate rar	31,00100	32. Registrar's	Signature	Joans S		4 20	d <u>6</u> 114	7 3000	1 11/ No y 1001

ORIGINAL

DORLINE   JOHNSON   As Facility Name (if not institution, give stress and number)   As Facility Name (if not institution, give stress and number)   As Facility Name (if not institution, give stress and number)   As Facility Name (if not institution, give stress and number)   As Facility Name (if not institution) give and and number   As Facility Name (if not institution) give and and number   As Facility Name (if not institution) give and and number   As Facility Name (if not institution) give and and number   As Facility Name (if not institution) give and institution   As Facility Name (if not institution) give and and number   As Facility Name (if not institution)   As Faci			1 - For State Registrar		of Maryland		artment rtificate			and M		Reg. No.	2004	15759
DOCUMENT OF THE PROPERTY AND THE PROPERTY OF T	Physic	ian			101						Month	Day		3. Time of Death
SOSE BRITCHED HOSPICE    10   25   7   7   7   7   7   7   7   7   7							4b. City,	Fown, or	Location of	of Death	Мау			2.20 a
South Security Number   Color   10	Exami	iei					BA	LTIM	ORE				N/A	
Top State   Doc Curry   Doc City		5. Social Security Number	6. Sex							(Month, Da	y, Year)	Cou	ntry)	
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	and *				10c. City	. Town or Lo	ocation							10d. Inside City Limits
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	Maryl: f sho	io		A		BAI	TIMOR	E						¥XYes 2 □ No
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	r 28a	irec								-		10g. Citíze	n of What Cou	ntry?
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	th with	al D	2815 VIOLET	AVENUE				21	215			U.	S.A.	
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	r dea	ner		Armed F	orces?	6. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14		
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	rs afte	oy Fi		l If Yes. G	iive		1 ☐ Yes 2	XXXXX	Specify:			S	pecify: BI	ACK
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	2 hou atura			s Education		16a. Dece	dent's Usua	I Occupa	ation	t of work	ing	16b. Kind	of Business/Ir	ndustry
GEORGE E MAYO  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  196 Mailing Address (Street and Ambreo or Plant Parker) (Cyper Prior)  201 Mayo Mother  202 Mayo Mother  203 Mayo Mother  204 Mayo Mother  205 Plant of Documents on 3   Plant of Documents on 3	thin 7	nple		1		life.	DO NOT us	e retired,	)	t of work	ing			
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Physician //Medical Examinents Set course find the death. Do not extent the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Between Original Betwee	of Hear		20a. Method of Disposition		ce	ace of Dispo	osition (Nan	ne of						
Physician //Medical Examinents Set course find the death. Do not extent the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Between Original Betwee	Page ment c		* 4 ☐ Donation 5 ☐ Other (Sp			ZION	CEMET	ERY		05-2	0-04	LANDS	DOWNE,	MARYLAND
Sequentially list conditions gauss in cost of the sequence of	Dant. Departiments any injure.		21. Signature Ingral Services	Roersee 40llW		W	ILLIA	МС	BROW	V COI		FUNE	RAL HOM	E P.A.
24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  1   Yes   2   No  25. Was case referred to medical examiner?  1   Yes   2   No  26. Place of Death (Check only one)  27. Manner of Death  1   Matural   S   Pending investigation of Could not be determined  28a. Date of Injury   28b. Time of (Month, Day Year)  28b. Time of (Month, Day Year)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  70. Was case referred to medical examiners of death (Check only one)  25. Was case referred to medical examiner?  1   Yes   2   No  25. Was case referred to medical examiner?  1   Yes   2   No  26. Place of Death (Check only one)  27. Manner of Death  1   Matural   S   Pending investigation of Could not be determined  28d. Describe how injury occurred  28d. Describe how injury o	death certificate be executed was a stending physician and unal-transit and for use as the burial-transit.	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yes	a	o (or as a consequence of or a consequence of or a consequence of or a consequence of or as a consequence of or a consequence or a consequence or	nence of):  nence of):  ncy death 3{ sath 5{	⊒Ectopic pr ⊒ Other <i>(sp</i>	egnancy ecity)			23e. Did t	23	d. Date of delive Month	onset and Death  Year  The cause of death?
25. Was case referred to medical examiner?  1	v req beer shou										24a. Was	an	24b. Were aut	opsy findings available
25. Was case referred to medical examiner?  1	The hard	omp									perfo	rmed?	death?	
1   Yes   2   No   1   Yes   2   No   27. Manner of Death   28a. Date of Injury   28b. Timpurity   28b. Time of Injury   28b. Time of Injury   28b. Time o	ian: italica ctor, p	· ·	25. Was case referred to medical						26. Place	e of Deat		-	2:-1	
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   5   Pending investigation   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   29f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   31. Date filed (Month, Day, Year)   32. Registrar's Signature   32. Registrar's Signature   33. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   35. Registrar's Signature   36. Registrar's Signatu	hysic hysic his ce al dire		1 ☐ Yes 2 No	1 , 1				//	4 🗀 140	ursing Ho		_	1-1-1-1	y) hospice
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29a. Certifier (Check only only only only only only only only	or Attenditure death	rtificat	3 Suicide 6 Could r	not be 28e. Pla							28f. Location ( City or To	Street and wn, State)	Number or Rui	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas If- Powell 101 w, Read St. Batto 21201  31. Date filed (Month Day Year)  32. Registrar's Signature	Hospitel 24 hours ( Funeral) etely filled		(Check only 2 Medical	Examiner: On the	basis of examinat									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas If- Powell 101 w, Read St. Batto 21201  31. Date filed (Month Day Year)  32. Registrar's Signature	To the within To the comple		29b. Signature and title of certifier				290	. License	e number			29d. Date	signed (Month,	Day, Year)
31 Date filed (Month Day Year) 32. Hegistrar's Signature	1		p- 1	Mags.	M.	D.		D	130	000	5	51	(21	94
31 Date filed (Month Day Year) 32. Hegistrar's Signature	X		30. Name and address of person	who completed ca	use of death (Item	23a) (Type	, Print)		0			0		
State Registrar MAY 1 8 2004  Annual  State Registrar MAY 1 8 2004		1	Thomas		Bogistra's Sing		1 00	1,	Keo	rd	54.	Batt	to	21201
					magistial's Signal	G	Ano.	1	,		•			

			State of Sta	of Maryland / Dep Ce	ertificate of I			ene g. No. 20	04 15760
	Physici /Medic	an	Decedent's Name (First, Middle, Last)     Dorothy Kemple				2. Date of Death Month	Day	3. Time of Death 0
	Examin		4a. Facility Name (If not institution, give street and not have a street a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street and not have a street a street and not have a stre	umber)	4b. City, Town, or Columb	Location of Death	1	4c. County o	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 € F	7. Age (In yrs. last birthday	Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 22,	Year) 1925	9. Birthplace (State or Foreign Country) Maryland
	anyland show	J.C	Usual Residence of Decedent  10a. State 10b. County  Many 1 and Hove and	10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 1 No
	ith the M or 28a-f	Directo	Maryland Howard  10e. Street and Number	Columb	10f. Zip Code		10	g. Citizen of W	hat Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itiem 27 Is marked other than "naturat", or Itema 23a or 28a-f show other traumatic event, Ina Medical Examinational Les multilized at	by Funeral Director	Armed F	2 X No iive	21 . Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 25 No	044 ispanic Origin? (Sp.n., Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race	S.A.  - American Indian, , White, etc.  White
21215-0036	_ 2 33	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 12	(Giv (1-4or 5+)	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of worl ()	king	6b. Kind of Bus	
Maryland	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 Is marked other than other traumatic event, the Me	To Be (	17. Father's Name (First, Middle, Last)  Andrew McDowell			18. Mother's Nam	ne (First, Middle, M. OWN	aiden Sumame	)
	nd 2 sho Ilth and ! 27 Is ma		19a. Informant's Name/Relationship (Type, Print)  Timothy McDowell (Neph		ling Address <i>(Street)</i> 88 <b>Stonega</b>			-	
Baltimore,	Pages 1 are lent of Hear nt: If item ry or othe	ĺ	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, ch	position (Name of ematory or other place	e)	Date 2	0c. Location - C	city or Town, State
Balti	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Licensee		22. Name and Addres Vitzke Fun 630 Edmon				
8760,	ate be executed /Medical /Medical sud /Medical sud   Medical-transit   Medical /Medical cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Fair University Cause (Disease or injury that initiated events c.	daused the death. Do not eleach line.  A STA ST  (or as a consequence of):  (or as a consequence of):					Approximate Interval Between Onset and Death MONHIS	
O. Box 6	the death certifica y the attending pl iched for use as t	Physician/Medic	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date Mont	of delivery th Day Year
ecords, P	eq eq	þ	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause giv	en in Part I.			bute to the cause of death?  B Probably 4 Munknown
$\alpha$	e law has by	Completed					24a. Was an autopsy perform	ed? de	ere autopsy findings available ior to completion of cause of eath?
of Vital	ysician: is certific director.	To Be C	The second secon	Inpatient 2 ER/Outpati	Account Account	er: 4 Nursing H	th (Check only one	)	(Specify)
Division o	ding I. After fune	Certification;	Natural 5 Pending (Mo	of Injury nth, Day Year) 28b. Time Injury	World 1 □	y at k? Yes 2 □ No	28d. Describe hov		
Divi	ital or Att urs after d ral Direct	Certifi	4 Homicide determined buil	e of Injury - At home, farm, s ding, etc. (Specify)		1	City or Town,	State)	r or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical				pinion, death occur	rred at the time, dat	te and place, ar	
	or To	-	29b. Signature and title of certifier  A Li	Khan Mi	D. D	433	23/	AAY	14,2004
			30. Name and address of person who completed ca	use of death (Item 23a) (Type LORY Registrar's Signature	DGE	ROAD	CoLu	MBI	MD 21044
Cr	Sta Regist	ar	MAY 1 8 2004 Sen	wa &	Loads				

			For State Registrar			of Marylar	•	artmen rtificate			and M		Reg. No 2	04	15761
ı	Physici	an	Decedent's Name (F									2. Date of De. Month	ath Day	Year	3. Time of Death
L I	/Medic	al	JEAN 4a. Facility Name (If no	I REN		umharl		4h City	Town or	Location of	of Death	MAY 16.		ty of Death	03371
	Examin	er	106 CHERRY		give street and in	ambery		4b. Oity,		BURNI			9,00	NE ARUND	NE!
	Funeral		5. Social Security Numb		6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under		8. Date of Bird (Month, Da			ace (State or Foreign try)
	Director		216-30-0134		1 □ M 2 XX	74	Yrs.	MOHUIS	Days	Hours	IVIII I.	04/25/19			LAND
	and w		Usual Residence of De 10a. State 10	cedent b. County		10c. Ci	ty, Town or Lo	cation						10	Od. Inside City Limits
	Maryl -f sho	ট্	MARYLAND	ANNE A	RUNDEL		GLEN BU	RNIE							1 □Yes XX No
	n 18a	Director	10e. Street and Numbe	r				10f. Zip	Code				10g. Citizen of	f What Count	try?
	23e c	ai D	106 CHERRY	LANE						21060			USA		
	tema tema	Funeral	11. Marital Status		Armed F	cedent Ever in U orces?	J.S. 13.	Was Deced	lent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ace - America ack, White, e	
36	rs afte	by F	1 Never Married 3 XXVidowed 4		od 1 Yes, G If Yes, G Year or	2 <b>文</b> 的 live Dates:		1 ☐ Yes	2 <b>)(N</b> 0	Specity:			Spec	ify: WH	IITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28a-f show ha Madical Examiner must be multifud at	ted	15	. Decedent'	s Education		16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of	Business/Ind	ustry
215	e. an 'n Med	Completed	(Specify of Elementary/Seconda		grade completed College	(1-4or 5+)	life.	kind of wor DO NOT us	nk done d se retired,	luring mosi )	t of work	ing			
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and	ould be fit Mental H Narked ott	Be	17. Father's Name (Firs							18. Motne	rs Name	e (First, Middle,	Maiden Suma	ime)	
Maryland	2 should be filed and Mental Hygi is marked other aumatic event,	ဥ	FREDERICK  19a. Informant's Name		HOLT ip (Type, Print)		19b. Mailir	na Address	(Street a			_RUTH_BRO al Route Numbe		n. State. Zio	Code)
	95 M ==		KATHY MARI	A BARA	ZOTTO - DAU	JCHTER						E, MARYLA	-		·
ore,	es 1 an of Heal fitem 2 r other		20a. Method of Disposi		3 Demoval from	1 .	Place of Dispo	sition (Nan	ne of ther place	9)		Date	20c. Location	- City or Tov	wn, State
Ë	Pag lent nt:i		`4 □Donation 5 □			· MA	RILAND I	NAT ME	1. PAF	RK .	5/19	/2004	LAURE	L, MARY	LAND
Baltimore,	permit. Page Depertment o Important: if any injury or once.		21. Signature of Fund	The state	عياتي	ink	- 1	. Name an				NK FUNERA	_		
	<b>a</b> □ = <b>a a</b>		23a. Part1. Enter the c	GRECORY	0 0	101148						GLEN BURN	_ · <del>-</del>		Approximate Interval Between
0,	Physician /Medical Examiner prival-Itausit prival-Itausit	Examiner	Immediate Cause (Fin disease or condition resulting in death)  Securitally list condit if any, leading to immediates. Enter Underlyin Cause (Disease or injuthat initiated events resulting in death) Last	ichs idiate ng iry	c	o (or as a consec	quence of):	5104	و ,	1-1-61	zr+	Di	5 C 140	9	Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pring in the past 12 mo 1 □ Yes 2 □ No 9 (\$\mathbb{X}\text{Unknown}	nths?	1 Live	utcome of pregn birth 2  Feta gnant at time of c nown	al death 3	]Ectopic pro						ate of deliver	y Day Year
	w requires tha been signed should be dei	by	Part II. Dther significat	nt conditio	ns contributing to	death but not res	sulting in the u	nderlying ca	ause give	n in Part I.					e cause of death?
I Records,	The law requate has been page 2 should	Completed											an 24b. sy rmed? 2 <b>(</b> No	prior to com death?	sy findings available pletion of cause of
Vital	iclen: Th certificate rector, pag	Be	25. Was case referred examiner?	to medical	Hamitalı				0.1			(Check only o			
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no	ding I h. After funer	tou	1 Natural 5	investig	,	of Injury nth, Day Year)	Injury	M	8c. Injury Work 1 □ Y	.? ′es 2 ∐!	- 8	200. Describe r	low injury occu	med	
Division	if or Attending after death. I Director: After d in by the fune	Certification;	2 Accident 3 Suicide 6 4 Homicide	Could n determi	ot be 28e. Plac	e of Injury - At h ding, etc. (Speci	ome, farm, str fy)	eet, factory				28f. Location (5 City or Tow	Street and Num m, State)	nber or Rural	Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 (Check only one)	☐ Certifying	g Physician: To the examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred avestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) and m date and place	nanner as sta , and due to t	ited. the cause(s)
	To tt withii To tt	Σ	29b. Signature and title	of certifier	4	De	puty	/ 29c	. License	number	0	-//	29d. Date sign	ed (Month, D	lay, Year)
	( _		Ullie	lea	P	(mo)	mg		1	06	05	7	5/1	8/4	
	<b>S</b>		30. Name and address	9-m	PI	Tenes	3 m		69	15	A	meri.	e 9	210	55
	Sta Registi	_	MAY 1 8			Registrar's Signa	g de	mila	1						

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. () 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Kuemmer 5 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner BALTIMORE BALTIMORE Kag lei If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday). Yrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 216-03-5295 Maryland Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any liqury or other traumatic event, the Medical Evanfret must be nutilised at DORS. 10d. Inside City Limits 10a. Stete 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Directo M BALTIMORE SALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2902 21234 by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 If Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1□ Yes 22 No Specify: Wn H. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) achinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Kuemmert 2010,0 ဥ 19a. Informant's ame/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cramatory or other place) Lowdon Park Cemetery 5 BACTIMURE MD 21234 Date 20c. Location - City or Town, State bria 5-17-0/ BALTIMORE, MP 22. Name and Address of Facility ACTIMORE, MD 21234 21. Signature of Funeral Service Lic EVANS FUNERAL CHAPEL 8800 HARFURD RO Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part I. Enter the disease, on shock, or heart fajiure. List 10 au Approximate Interval Between Onset end Death complications that caused the death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEMENTIA I waterless Due to (or as e consequence of) Physician/Medical Examiner ettending physician end for use es the bunel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? After this certificete has been signed by the e funeral director, page 2 should be deteched to 1 ☐ Yes 2 No 3 Probably 4 Unknown P0012 DRAL INTAKE þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? DEHYDRATION To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has 1 ☐ Yes 2 ☐ No 1 LI Y63 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Deeth 28d. Describe how injury occurred Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide completely filled in by 4 - Homicide

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

31. Dete filed (Month, Dey, Year) MAY 1 8 2004

29b. Signature and title of certifier

29a. Certifier

Check one)

PAMICAJ

Medical



30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

oocks

1 x c-rtifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

00066500

BACK RIVER NECK RS BALTIMORE, MD

29d. Date signed (Month, Day, Year)

1- State Registrar Amend Item #23a per me G833 Certificate of Death 128/04 tas Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month KENT **Physician** EDITH May 13, 2004 10:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) October 2, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 158-26-9295 6. Sex **Funeral** Days 1 M XX F New Jersey Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 7 is marked other than "natural", or Items 23e or 28a-f show traumatic event, the Medical Examinar must be notified at PENNSYLVANIA Chester 1 Yes 2XXNo Malvern, East Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19355 196 Applebrook Drive USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 200 No If Yes, Give Year or Dates: 1 Never Married 2XX Married altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Page Carrie Dehn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Kent 196 Applebrook Drive Malvern Pennsylvania 19355 item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 tment of h 1 ☐ Burial 2XXCremation 3 ☐ Removal from State ö Department of Important: If any injury or once. RA Ferris & Co. 5/18/04 West Chester, Pennsylvania \*4 ☐ Donation 5 ☐ Other (Specify) Anature of Funeral Sivice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Cnas 6500 York Road Baltimore, Maryland 21212 unnes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a part of the shock, or heart failure. List only one Hypoxic Encephalopathy Due To Hypertensive Episode Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Under Anesthesia For Lumbar Laminectomy Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. detached 9 Unknown 9 Anknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Hypertensive Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ es 2 □ No 24a. Was an page 2 s has autopsy performed? 18 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA P nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 15, 2004 OCME wes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 0 ANA RUBIO, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 8 2004

			1 - For State Registrar	State of Marylan	d / Department of Certificate	of Health and N of Death	Mental Hygie	
	Physicia		1. Decedent's Name (First, Middle) Las	1121 K	N, JhT		2. Date of Death Month	Day Year 3. Time of Death
*	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give 263/Amp)  5. Social Security Number  6. Se	RWELL Co.	URT Worlday) If Under 1 Y	on, or Location of Death  A WA  Bear If Under 24 Hrs.  Bays Hours Min.	8. Date of Birth	9. Birthplece (State or Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State  10b. County	more 10c. cit	ty, Town or Location	imore		10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28s	Funeral Director	10e. Street and Number 2631 Camber We	11 Court	10f. Zip Co	21244	10g	, Citizen of What Country?
036	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show the Maufrel Exactinet must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	.S. 13. Was Decedent If Yes, specify 1 Yes 2	of Hispanic Origin? (S Cuban, Mexican, Puerto No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinational templified at ance.	Completed	(Specify only highest gra-	cation le completed)  Collège (1-4or 5+)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use r	ccupation fone during most of wor etired)	king 16	ED. Kind of Business/Industry
Maryland	should be filed nd Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last)	HT		Sur	BYNL	ım
	s 1 and 2 sho Health and tem 27 Is m other traum		19a. Informant's Name/Relationship (1) 20a. Method of Disposition	lunes (Dghtr)	19b. Mailing Address (S	Ave. Apt 1	611, Bat	City or Town, State, Zip Code)  C. Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If Its Important: If Its any injury or o		1 Surial 2 Cremation 3 Companies 5 Other (Specify 21. Signature of Funeral Service Licen	Hemoval from State	Ling Park	ddress of Facility	14-04 ughn C G	Baltimore MD breene Funcial ruc
A.	Physician	i	23a. Part1. Enter the disease, or come shock, or heart failule. List only immediate Cause (Final disease or condition	olications that caused the dear one cause on each line.	th. Do not enter the mode of	f dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
,109	/Medical Examiner  hysician and he prinal-transit	cal Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  d.	quence of):			
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Δ.	es pe	d by Ph	Part II. Other significant conditions of	* .	sulting in the underlying caus	se given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Annhown
Il Records,	The law ate has b page 2 sl	Completed by					24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) 2 \( \text{No} \)
f Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Vyes. 2 \( \text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DOA	Othor	ath <i>(Check only one)</i> dome 5 <b>√</b> Residend	ce 6 Other (Specify)
ion of	ding h. After fune	atlon: T	27. Many r of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	Injury at Work? 1 Tes 2 No	28d. Describe how	injury occurred
Division	in Sire	Certification:	3 Suicide 6 Could not b determined	building, etc. (Speci			City or Town,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical		ysician: To the best of my kn niner: On the basis of examin and manner stated.				ise(s) and manner as stated. e and place, and due to the cause(s)
	To the within To the comp	×	29b. Signature and little of certifier	1.6 - 5	29c. L	icense number	10	d. Date signed (Month, Day, Year)
	5		30. Name and address of person who	completed cause of death (Ite	m Z3a) (Type, Print)	a Lange a	2110	414, 2004 City, MALYMAND
	St Regist	ate rar	31. Date filed (Month, Day, Year)	AMDON # 32. Registrar's Sign	adure A A A A	7 - 41 1 6		-107- MARYEMANS

			1 - For State Registrar	State of Mar	yland / Depa <i>Ce</i> a	artment of I	Health an <i>Death</i>	d Ment		ene 2 0	04	15765
	Physici	an	1. Decedent's Name (First, Middle, Last	')					ate of Death	Day	Year .	3. Time of Death
	/Medic	al	Mabel  4a. Facility Name (If not institution, give	etreet and number)	Lytle	4b. City, Town,	or Location of D		1	4c. County	op of	M LOST W
	Examir	er	NORTH ARUNDA		TAL	GLEN	Beliz			Ann	E A	BUNDEL
	Funeral Director		5. Social Security Number 6. Se 170-24-7319	x 7. Age (	In yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days		Hrs. 8. Da Min. Ju	ate of Birth fonth, Day, Y			
	and		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	ocation					10	Od. Inside City Limits
	Maryl -f sho	tor	MD Anne Aru	nde1	Glen Bu	rnie						1 ☐ Yes XXNo
	h the or 28a s notif	Director	10e. Street and Number			10f. Zip Code			10g	. Citizen of W	/hat Coun	try?
	ath wi	rai	8090 East Phirne	Road		210				USA	1	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinating the notified at once.	by Funerai	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No		? (Specify Y uerto Rican	es or No- , etc.)		America k, White, e	
21215-0036	in 72 hou n *nature	Completed	15. Decedent's Education of the Community of the Communit	le completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	working	16	b. Kind of Bu	siness/Ind	lustry
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ζ	y Men marka natic	၉	George K. Smit				!	Ruth J				
<u>g</u>	d 2 st th and th and traun		19a. Informant's Name/Relationship (T)  Ms. Beverly Lytle			G Address (Stree						
Baltimore, Maryland	Pages 1 an ent of Heal nt: If itam 2 ry or other		20a. Method of Disposition  1 \( \begin{align*}     \begin{align*}     & \text{Donation} & 2  \text{Cremation} & 3  \text{F} \\     & \text{Donation} & 5  \text{Other} & (Specify) \end{align*}	Removal from State	20b. Place of Dispo	natory`or other pla	ice) Ma	Date v 17	20	c. Location -	City or To	wn, State
Balti	permit. I Departm Importa eny inju		21. Signature of Edineral Service Licens		22	Name and Address	ess of Facility S	Single	ton Fu	lkrid neral urnie,	Home	P.A.
ŗ			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the ne cause on each line.	e death. Do not ent	er the mode of dy	ng, such as car	diac or resp	iratory arrest			Approximate Interval Between
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Ω.	The law requires that the de tile has been signed by the bage 2 should be detached	Ph	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause gr	ven in Part I.	23	3e. Did tobac	co use contri	bute to the	a cause of death?
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Record	sw requir s been si s should	olete						24	a. Was an	24b. W	ere autop	sy findings available
Ä		Completed						_	autopsy performed ☐ Yes 2  ☑	17 de	ath?	pletion of cause of
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uc	ding f	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	eer) 28b. Time of finjury	28c. Inju Wo	ryai rk?  Yes 2 ∐No	28d. D	escribe how	injury occurre	d	
Division of Vital	To the Hospital or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stri Specify)			28f. Lo	cation (Stree ty or Town, S	t and Numbe State)	r or Rural	Route Number,
	To the Hospital within 24 hours a To the Funaral I completely filled	edical (	29a. Certifying Phy (Check only one)	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or inv	occurred at the ti	me, date and pl opinion, death o	ace, and du	e to the caus ne time, date	e(s) and man and place, ar	ner as sta nd due to t	ted. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		Mi	29c. Licens	se number	G	29d.	Date signed	(Month, D	ey, Year)
7	7.6		Pie Sur	7		1.04	7.7	(	11	rating	10	100
	9		30. Name and address of person who co	3: 301	ACC1519	Print)	rive t	Ster	Bu	mie	mi	201061
	Sta Registr		MAY 1 8 2004	32. Registrar's	Signature	mel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Recistrar AMEND ITEM #8 PER FH C831 5/21/04 JEC ertificate of Death Reg. No 2 0 1 4 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04 2 2004 EON 15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth SEP, 6,1936 Birthplace (State or Foreign Months Days Hours Min. 5 Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** -54-166 68 Months 1 M 2 □ F 4. 6,1935 NORTH CAROLINA Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show or other traumatic event, the Madical Exercitiver roust be notified at 1 Nes 2 No Director MARYLAND 10e. Street and Number Og. Citizen of What Country? RANC15 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 is marked other then "natural", or Specify: BLAC Specify 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RUCK DRIVER ONTRACTOR TITGRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trav once. ALTHOR MD. 2/2/7 20c. Location - City & Town, State VONNE E. LANGLEY (WIFE) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MT.ZION CEMETERY 05-21 LANSDOWNE, MARYLAND 22. Name and Address of Facility BROWN 20 SEPH H. BROWN 2140 D. FULTON AVE. 21. Signature of Funeral Service Licensee JR, FUNERAL HOME BALTO, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Doursia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner the ettending physician and hed for use as the burial-transit that initiated events resulting in death) Last requires that the death certificate be exec Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day signed by the eld 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 has 2 No 2000 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical \_examiner? Be 26. Place of Death (Check only one) Other: Yes 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 5 | Pending 1 🗌 Yes 2 □ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide To the Hospital 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only 29d. Date signed (Month, Day, Year) 29b Signature and little of certifier 29c. License number

State

Registrar

31. Date filed (Month, Day, Year)

Leah Wordell.

MAY 1 8 2004

2401 W. BELVEDERE AVE. BALTIMORE, M.D. 21215 32. Registrar's Signature

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smai

D58910

15,2004

	1	For State Registrar	State of Ma	,		rtificate				F	leg. No.	200	+ L	576
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ıer	4	a. Fecility Name (If not institution, g	spital Cent	0.30				Location of				Carrol;		
	5	. Social Security Number 6.	Sex 7. Age	(In yrs. las	st birthday)	If Under	1 Year	If Under		8. Date of Birtl			thplace (Sta	ate or Fore
		213-32-6476	1□ M 20XF	68	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl Month, Day Feb. 1	3,19	36 1	quintry) Maryla	nd
	-	Usual Residence of Decedent  Oa. State 10b. County		10c. City,	Town or Lo	cation							10d. Insid	le City Lin
ţ	5	Md. Carro	11		Mano	heste	er						10	Yes 2 🛚
Director	1	0e. Street and Number 2627 Bachm	on Dd			10f. Zip	Code 2110	12				zen of What C	ountry?	
Funeral	5	1. Marital Status	12. Was Decedent E	ver in U.S.	13	Was Deced			pin? (Spe	cify Yes or No-		14. Race - Am	erican India	n.
by Fun		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No lif Yes, Give Year or Dates:			f Yes, spec 1 ☐ Yes			, Puerto f	cify Yes or No- Rican, etc.)		Black, Whi		
eted		15. Decedent's (Specify only highest of	Education		16a. Dece	kind of wor	rk done a	uring most	t of workin	ng	16b. Ki	nd of Business	/Industry	
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		7. Father's Name (First, Middle, La:	st)			110 40	, C W 1. 1		r's Name	(First, Middle,				
To Be	3	Joseph Wi	lson					I	Blanc	he Bell	L			
		19a. Informant's Name/Relationship				•				Route Numbe				211
	>-	Edgar E. LaMo	tte - Husba							Box 35				
	2	t0a. Method of Disposition 1  Surial 2  Cremation 3	Removal from State		ce of Disponetery, cred			9) Mar		2004 1		cation - City or		ө
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cal Exa	1	hat initiated events resulting in death) Last	C. Due to (or as a	conseque	nce of):									
			d											
Physician/Med	) SICION I	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal d	leath 3[	Ectopic pr Other (sp					2	23d. Date of de Month	Day	Year
by Ph	F	Part II. Other significant conditions	contributing to death bu	t not result	ing in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco u	se contribute t	o the cause	of death?
										1 □ Y	es 2[	∃No 3□P	robably 4	Unkno
Completed	- J									24a. Was a autop perfor	sy	24b. Were a prior to death?	completion	ngs availa of cause
Be	0	25. Was case referred to medical examiner?			*		-10-11-		of Death	(Check only or	10)			
P	- 1	1 Yes 2 Ho	Hospital:		R/Outpatier		A Othe	4 Nu		ne 5 🗆 Resid			ecify)	
lon		1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	M	Work	:? /es 2 □ I		od. Describe n	ow injur	y occurred		
Certification:		2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be age Blace of Injur		ne, farm, str	eet, factory			-	8f. Location (S City or Tow	treet and n, State,	d Number or R	ural Route I	Vumber,
Medical C		29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of aminer: On the basis of and manner stall	examination	iedge, deat on and/or in	h occurred vestigation,	at the tim , in my or	e, date an pinion, dea	d place, a	nd due to the co	ause(s) late and	and manner a place, and du	s stated. e to the cau	se(s)
M	E	29b. Signature and title of certifier				290	. License	number		2	9d. Dat	e signed (Mon	th, Day, Yea	ır)
		> Chan W	", middle	itm			1) 2	54	43		51	1/7/2	004	1
		30. Name an address of person wh	o completed cause of de	ath (Item 2	23a) (Type,	Print)			-		-/	, , , -	/	
1					688					stunn				

State of Maryland / Department of Health and Mental Hygiene 2004 15768 1 - For State Ragistra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Moore Month | Day | 2004 **Physician** 02:40 AM Hazel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE 3601 W. MULBERRY STREET 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 219F Days 220-20-806 81 13 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County rthen "natural", or items 23s or 28s-f show the Medical Examinar must be notified at BAUTIMORE 1 XYes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2/2201 3601 W. MULBERRY STREET within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: BLACK ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE X-RAY TECHNICIAN N/A 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any jinty or other traumatic event anys. Be HANNAH STITH GARFIELD HICKS ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3601 W. MULBERRY STREET BALTO. MD 21229 CALOTTA WELCH 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 DCremation 3 ☐ Removal from State GREENMOUNT CREMATER 05/19/04 BALTIMORE, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
CREMATION SERVICES 21. Signature of Funeral Service License 5151 BALTIMORE NATIONAL PIKE BALTO MD 21229 04 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End liver Physician stage /Medical Examiner Henatins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Meilitur 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No decubitus 24a Was an 1X Yes 2□No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 247804 05/13/2004 ( Duiei 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 Aberdeen Plaza. Averdeen MD 21001 10 Mrowiec 32, Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

					State of IV	iai yiai iu 7	-	tificate of				eg. No. 2	ΠL	15769
			1. Decedent's Name (First,	Middle, Le	st)					2	. Date of Deel	th Day	Year	3. Time of Death
	Physicia /Medic		Marion Eliz	abeth	Mauk					9	Tay		04	10:50 PM
	Examine		4a Facility Name (If not inst	itution, giv	e street and number	)			4b. City, To	own, or Loca	tion of Death	4c. County	of Death	
			Keswick Hom	e					Balti					
	Funeral		5. Social Security Number	6. S	ex 7. A	ge (In yrs. last b		If Under 1 Yea Months Days		Min.	Date of Birth (Month, Dey	Year)	9. Birthp Cour	olace (State or Foreign ntry)
3	Director		170-12-6552			84	Yrs.				Jul 3,	1919	Pen	nsylvania
	pu *	ŀ	Usuel Residence of Deceder 10a, State 10b, C			10c. City, To	wn or Loc	ation					1	10d. Inside City Limits
	aho	5				2 3	, .							1 ☐ Yes 2 ☑ No
	28a-1	2	MD HC	ward		Colu	mbla	10f. Zip Code			1	0g. Citizen of W	hat Cour	ntry?
	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mentel Hygiena. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	Funerai Director			7.4			21044				United	C+ at	tos
	9eth	era	5482 Cedar I	ane,	APT A4 12. Was Deceden	t Ever in U,S.	13. W	as Decedent of Yes, specify Cu	Hispanic Or	igin? (Speci	fy Yes or No-		- Americ	can Indian,
_	Ter d	튒	1 Never Married 2 □	Married	Armed Forces						can, etc.)		k, White,	etc.
20	Irs at	þ	3 ☐ Widowed 4 ☑ Div		If Yes, Give Year or Dates			☐ Yes 2 12 No	o Specify:	:		Specify:	Whit	- 6
Maryland 21215-0020	2 ho	Completed		edent's Ed		16	a. Deced	ent's Usual Occ	upation	et of working		16b. Kind of Bu		
215	hin 7	e D	Elementary/Secondary (0	<del>- i</del>	de completed) College (1-4o	5+)	life. D	ind of work don O NOT use retin	red)	st or working		Higher	Educ	cation
21	d wit	팃	12				House	mother						
pu	be file d oth	Be	17. Father's Name (First, M	iddle, Last)					18. Moth	er's Name (	First, Middle, i	Maiden Sumam	θ)	
<u> a</u>	Vented vented in the original	၉	Roy Ehrenf	eld						rl Ri				
an'	2 should be filed end Mentel Hygi is marked other sumatic event, is		19a. Informant's Name/Rel	ationship (	Type, Print)	15	b. Mailin	Address (Stree	et and Numb	er or Rurel I	Route Number	r, City or Town,	Stete, Zip	o Code)
	1 end 2 Health em 27 i	- 1	Mrs. Ruth D	umont	/Daughter		11308	Tooks	Way,	Columb	oia, MD	21044		
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremi	ation 3	Removal from Stat		of Dispos ery, crem	ition (Name of atory or other p	lace)	M		20c. Location -	City or To	own, State
Ĕ	permit. Pages Department of h Important: If the any Injury or of		4 □ Donation 5 □ Ot				sapea	ke Crem	atory	2	ay 18 004	Beltsvi	lle,	MD
alti	mit.	- 1	21. Signature of Funeral Se	rvice Licer	1500	40088	22.	Name and Add	ress of Facili		7.7.4			
œ	P P E G	- 1	1	Lu	ell-	roeio		8717 Gr				ternativ e Balti		e, MD
			23a. Partt. Enter the disea shock, or heart failure	se, or com	plications that caus	ed the death. Do	o not ente	r the mode of d	ying, such as	s cardiac or	respiratory arr		1	Approximate Interval Between
No.	Physician		snock, or near failure	. List only	i A	III 9.							1	Onset and Death
-	/Medical		Immediate Cause (Final disease or condition		Lung (	ancer	hui	the live	er yn	exasi	lases		;	2 months
	Examinet .	2 0	resulting in deeth)		a	Due to (or as							i	
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	tificata be axecuted g physician end es tha bunal-transit	Examiner	Sequentially list conditions		D	Due to (or as	a consequ	uence of):					1	
Ö,	e axe ian e urial-l	Ě	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										]	
68760,	ata ba nysici ha ba	edical	that initiated events resulting in death) Last	1	C	Due to (or as a	consequ	ence of):					į	
	ng pt	Me	, , , , , , , , , , , , , , , , , , , ,	L	a.								İ	
Вох	The law raquiras that tha daath centate has been signed by the ettendingta has Should be detached for use	Completed by Physician/M			d		-						1	
	n daa he et hed fo	SICI	Part II. Other significant co	nditions o	ontributing to death	but not resulting	in the un	derlying cause	given in Part	1.	23b. Did to	obacco use con	tribute t	o the cause of death?
P.0	at the	F	Chronie	Olis	fruetive	lun	a a	lisea	20_		1 🕮	es 2□ No	3 Pro	babiy 4 Unknown
	as the	ρ	go agoce	-		(	1						0.45 141	fore systems findings
PZ	aquir en s ould	द्ध									24a. Was a perfor	in autopsy med?	av	lere autopsy findings vailable prior to empletion of cause
Records,	aw rass be	Pie l												death?
E.	The I	Ö									±□Y	05 2 No	11	☐Yes 2☐No
Vital	lan: rtifica ctor,	Be (	25. Was case referred to a examiner?	fedical						e of Death	Check only or	16)		
of <	Physician: r this certific ral director,	2	1 ☐ Yes 2 ☐ No		Hospital: 1 Inpa		Outpatien	3LI DUA				ence 6 □Othe		fy)
0	Ng PP ter th		27. Manner of Deeth 1 ☑ Natural 5 ☐ I	Pending	28a. Date of Ir (Month, L	jury 28b Dey Yea <i>r)</i>	. Time of Injury	28c. In W			ld. Describe h	ow injury occurr	ed	
<u>Ö</u>	Attending ir deeth.	atic	2 Accident	nvestigatio					☐ Yes 2 ☐					
Division	r Atte	Ę.		determined	286. Place of I	njury · At home, etc. <i>(Specify)</i>	farm, stre	et, factory, offic	ee ·	28	City or Tow		er or Hur	al Route Number,
	To the Hospital or Attending Physician: The law raquiry within 24 hours aftar deeth.  To the Funerel Director: After this certificata has been si completaly filled in by the funeral director, paga 2 should	edicai Certification:												
	To the Hospital within 24 hours To the Funeral completaly filled	cai	(Check only 2 Me	rtifying Ph dical Exa	nysician: To the bes miner: On the basis	of examination a	ge, death and/or inv	occurred at the estigation, in my	time, date ai y opinion, de	nd place, an ath occurred	d due to the of at the time, o	ause(s) and ma late and place, a	nner as s and due t	steted. to the cause(s)
	the the the plant	Med	one)	nortifier	and manner	stated.		29c Lice	nse number			29d. Date signed	(Month	Day, Yeer)
	Verit verit		29b. Signature and title of	10.4	la a Quo	מנד מנו	1		657		1			. (
	^		- marche	le '	- Je	7			03/		· ·	lay 17,	voc	/
	17	)	30. Name and address of p	erson who	completed cause o	death (Item 23a	(Type, I	Print)	D 67. 1	2017	17200	, 070 2	121	1
	)		11. 18 HBELLE	1 (/	K7KE411	1	, T	04 30%	C C 1 / 1.	115611	12016	1 000		/
	Sta		31. Date filed (Month, Day,		32. Regis	strar's Signature	•	1						
	Registr	ar	MAY 1 8	2004	Gener	وشر مصد	1	frank.	<i>i</i>					

DHMH 16 Rev 6/95

			For State		partment of Health and Nertificate of Death		F004 10110
			Registrar  1. Decedent's Name (First, Middle, Last,		Crimeate of Beath	Reg. 2. Date of Death	3. Time of Death
	Physici /Medic		Charles	F. Miller		May	13 2004 8:58P. M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death  BALTIMOYE		BALTIMORE
	Funeral		5. Social Security Number 6. Sec	(	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	
	Director		Usual Residence of Decedent	QM 2∐F Yrs		3-31-	33 Maryland
	nytand thow		10a. State 10b. County	10c. City, Town or			10d. Inside City Limits
	the Ma 28a-1 e	Director	100. Street and Number	nore Bac	TI MORE	10a	1 ☐ Yes 2 No
	h with		8013 HARRIS	Ave.	21234		USA
	er deat	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ehow titem 27 is marked other, the Madical Examiner must be neithed at	5	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White.
21215-0036	"natur	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (G	ocedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)		b. Kind of Business/Industry
2121	s within jiene. r than "	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	DOLU Officor	S.	tate Lottery Comm.
nd	be filed ntal Hygie od other	Be	17. Father's Name (First, Middle, Last)	AL 241	0.	e (First, Middle, Mai	iden Sumame)
Maryland	2 should be and Ment is marked aumatic	ဥ	19a. Informant's Name/Relationship (T)	TOP. Print) 19b. M	ailing Address (Street and Number or Rur		Man. State, Zip Code)
	1 and 2 s Health ar em 27 is other trau		A1 . 11	1-wife. 801	3 HARRIS AVE,	BALTIMO	AD 217211
Baltimore	00		20a. Method of Disposition  1 Description 2 Cremation 3 F	lemoval from State cernetery,	crematory or other place)	400	c. Location - City or Town, State
Him			<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>	Holly Hi	11 Centery 5 1	1-04) IN	adde River MD
B	permit. Deportr Importe any inji	- 3	Kinberly ().	Zavrotacy	EVANS FUNERAL CH	APEL SRO	CHARFORD RD.
П			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the reath. Do not no cause on each line.	enter the mode of dying, such as cardiac		Approxi te Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due t (or as a consequence of):	RDIAL INFAR	CHON	ACUIT 4 WKS
	Examiner		Sequentially list conditions,	ISCHE		OMYOP	ATTY 2 YRS
	rted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	RESPIRATO	KY FA	HLUPE Z YKS
oʻ	cate be executed oblysician end the burial-transit		resulting in death) Last	Due to (or as a consequence of):	10a W 10a	1000	Hule
98760	cate phys	dicai		a Pacaoni	ARY FIBRO	3/5	7773
Вох 6	The law requires that the death certific tte has been signed by the attending to page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	3 ☐ Ectopic pregnancy		23d. Date of delivery
.O. B	the attr hed for	/sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
Δ.	that the dended by the a	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ords	w requires been sign should be	ted b	- Empt	YSEMA		1 X Yes	2 No 3 Probably 4 Unknown
Records,	e law r has be je 2 sh	Completed				24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death?
Vital		a	25. Was case referred to medical		26. Place of Deat	1 Yes 2	No 1 Yes 2 No
of Vi	d is	To B	1 105 22 110	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing Ho	ome 5 Residenc	e 6 □Other (Specify)
	ling After fune	tion:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Injur		28d. Describe how	injury occurred
Division	r Attending er death.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	pital or rurs afte erel Dire		29a. Certifier 1 Certifying Phy		eath occurred at the time, date and place,	and due to the save	so/s) and manner so stated
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only one) Medical Exemi	ner: On the basis of examination and/o	r investigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To the To the Comp	Ň	29b. Signatule and title of certifier	1 in - MAR	29c. License number	29d.	Date signed (Month, Day, Year)
,	X		30. Name and address of person who co	ompleted cause of death (Item 23a) (Tu	D/ L7 T L		3-17-04.
	M		DR. JACK NISS	IN 1838 GREEN	TREE Rd. Pikesvi	11e MD	21208
	Sta Regist		31. Date filed Aventy Day Year 2004	32. Registrar's Signature	PREE Rd., Pikesvi	•	

			1 - For State Registrar	State of Maryla		artment of rtificate of			giene Reg. No. 2 ()	04 15771
	Physici /Medio Examir	at	Decedent's Name (First, Middle     A. Facility Name (If not institution,	FICANIK give street and number)	7 /		or Location of Dea		Day	Year 3. Time of Death 1
	Funeral Director			10 pkus Hcop 6. Sex 11 M 2 □ F 68	i. last birthday) Yrs.	If Under 1 Year Months Days		s. 8. Date of Birt	N/A 1936	9. Birthplace (State or Foreign Country) Maryland
	h the Maryland or 28a-f show	Irector	10a. State 10b. County	第	ity, Town or Lo		***		10g. Citizen of W	10d. Inside City Limits 1 □ Yes 2 M No  What Country?
336	72 hours after death with the Maryland natural', or Items 23a or 28s-1 show dical Examanar must be motified at	by Funeral Director	21 Hickory Rid	12. Was Decedent Ever in I	u.s. 13. Y	1		Specify Yes or No- rto Rican, etc.)	U.S 14. Race Black Specify.	e - Americen Indian, k, White, etc.
21215-0036	d within plene. r then "	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	college (1-4or 5+) 4 years	(Give	dent's Usual Occu kind of work done DO NOT use retire Engineer	e during most of wo			of Baltimore
Maryland	a ta b	To Be	17. Father's Name (First, Middle, L Gilbert Thoma 19a. Informant's Name/Relationsh	s Michaels	19b. Mailir	ng Address (Stree	Louise	ame (First, Middle,	Cavallo	)
	Pages 1 and 2 should nent of Health and Mer int: if item 27 is marke iry or other traumatic		Anne Michaels  20a. Method of Disposition  1 Burial 2 MCremation		21 Hi	ckory R	idge Ct.	Baltimo	re, Mary	land 21228 City or Town, State
Baltimore,	permit. Pag Department Important: I eny injury o		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		een Mou Mi	nt Crema Name and Addr tchell-V	atory 5- ess of Facility Viedefeld	18-04   Funeral   Baltimore	Baltimor Home, I	re, Maryland Inc. and 21212
8760,	Physician /Medical Examiner portion and provider transit trans	Ical Examiner	23a. Part 1. Enter the disease, or or shock, or heart failurel. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ARDS - +  Due to (or as a conse  b. Pneumov  Due to (or as a conse	quence of):	Respise	ing, such as cardia	ic or respiratory arr	est,	Approximate Interval Between Onset and Death
P.O. Box 68	death certific e attending p id for use as l	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 \( \subseteq \text{Live birth} \) 2 \( \subseteq \text{Fet} \) 4 \( \subseteq \text{Pregnant at time of } \) 9 \( \subseteq \text{Unknown} \)	al death 3 🗌	Ectopic pregnand Other (specify)	у		23d. Date Mon	e of delivery th Day Year
Records, P	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant condition	s contributing to death but not re	sulting in the un	nderlying cause gr	ven in Part I.	23e. Did tol	_	bute to the cause of death?
Vital Reco		e Completed	25. Was case referred to medical						ned? de 22 No 1 €	fere autopsy findings available for to completion of cause of path?  Yes 2 No
Division of Vi	fing Phys I. After this funeral di	Certification; To B	examiner?  1  Yes 2 K No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju Wo	her: 4 Nursing h	ath (Check only on Home 5 Reside 28d. Describe ho	ence 6 Other	
DIVI	Hospital or Attend 24 hours after death Funeral Director: tely filled in by the		4 ☐ Homicide determin	building, etc. (Speci	owledge death	occurred at the ti	me, date and place	City or Town	n, State)	r or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled it	Medical	(Check only 2 Medical E	xaminer: On the basis of examination and manner stated.	ation and/or inv	estigation, in my o	opinion, death occi	urred at the time, da	ate and place, ar	(Month, Day, Year)
	jo		30. Name and address of person w	ho completed cause of death (Iter	m 23a) (Type, F		96 C. Ball	L	Tay 16	2004
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signi	ature	Sports	1	more,	THY E	- 6 1

MICHAELS, RALPHIF &

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 40 9. **Physician** MEYERS 2004 14 6 OHN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMUR HUSPITAL HARBUR ENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 17,1925 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min MD 78 Director 219-10-5465 Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10b. County 10a, State show or than "natural", or items 23a or 28a-f show the Medical Expressor must be notified at 1 ☐ Yes 2 No Director Linthicum Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 U.S.A. 402 North Hammonds Ferry Road Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 (X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Electrician 8 it of Health and Mental Hyg if Itam 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fiil Department of Health and Mental Hy Important: If Itam 27 ie marked oth any injury or other traumatic even Be Myrtle Watts John J. Meyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5516 Patrick Henry Drive, Baltimore, MD 21225 Mr. John A. Kaline / nephew 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery May 20,2004 Brooklyn, MD 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature Funeral 1 Second Avenue S.W., Glen Burnie, MD 21061 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** emmorthag disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c) as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): attending physician 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day for 5 Other (specify) P.O. been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one director Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral o 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier eno 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) N INKO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 8 2004 Registrar

**ORIGINAL** 

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			. For	State of Ma	aryland / D	epartme	nt of He	ealth and	Mental H	lygien		2.1	g 250 s	7 77 0
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			1. Decedent's Name (First, Middle, L	ast)					2, Date of				3. Time o	of Death
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1	/Medic Examin	-	4a. Fecility Name (If not institution, gi				y, Town, or I	Location of Dea		40	c. County o			
	Exami	ei		TAN H	OSPITAL		BALT	imo	RE					
	Funeral				e (In yrs. last birtl	hday) If Unc	er 1 Year	If Under 24 Hr	s. 8. Date of	Birth		9. Birthp	itace (State	or Foreign
₹	Director		023-07-7020	1 <b>∑</b> M 2□F	87 Y	rs. Month	s Days	Hours Mir	Dec 2	0.19	916	Cour	itry)	unk
-			Usual Residence of Decedent							,				
	yland		10a. State 10b. County		10c. City, Town	or Location						1	0d. tnside (	
	Mar Mar	to	MD		Baltir	nore							1 <b>∑</b> Yes	2 🗆 No
	128g	irec	10e. Street and Number			101.	ip Code			10g. C	itizen of W	nat Cour	ntry?	
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	within 72 hours after death with the Maryland ene. Than "natural", or fleme 23a or 28a-f ehow na Medical Esacidinar must be collified at	Funeral Director	11. Maritat Status un	k 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	edent of His	panic Origin? (	Specify Yes or into Rican, etc.)	No-			an Indian,	
က	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	1   Yes 2		-	2⊠ No		into moan, etc.)			, White,		
93	al', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Tes	ZINO	<i>эрөспу:</i>			Specify:	W	hite	
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21	d with giene.	On	unk	unk										
b	buld be filed Mental Hygid arked other atic event, II	Be (	17. Father's Name (First, Middle, Las	st)			unk	18. Mother's Na	ame (First, Mide	dle, Maide.	n Sumame	)		unk
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Maryland			19a. Informant's Name/Relationship			-			Rural Route Nur			tate, Zip	Code)	
	and 2 alth 27 i		Good Samaritan H	ospital	5	601 Lo	ch Rav	en Blvd	l Baltim	ore,	MD	2123	9	
re	permit. Pages 1 and 2 sh Department of Health and Importent: if Item 27 is n any injury or other traum		20a. Method of Disposition	<b>7</b> 8 14 8:::	20b. Place of cemeters	Disposition (A	lame of rother place	,	Date	20c. L	ocation - C	ity or To	wn, State	
Ë	Page ent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☒ Other (Spec	⊔Hemoval from State :ify) in starte										
Baltimore,	orte inju			ensee . c //.		22. Name	and Address	s of Facility	. 1 6EE T	D -	1 4 4			
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			23a. Part1. Enter the disease or co shock, or heart failure. List on	mplications that cause	the death. Do n	ot enter the m	ode of dying	, such as cardi	ac or respirator	arrest,			Approxima	ite
	16		shock, or heart failure. List on Immediate Cause (Final										Onset and	Death
	Physician /Medical		disease or condition resulting in death)		RATIC		1106	UMON	JIM					
а	Examiner			Due to (or as	a consequence of	or).								
ш		9	Sequentially list conditions,	b. Due to (or as	a consequence o	of):						-		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
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687	tificate ig phys as the			d										
×	eath certificate be exattending physician for use as the buria	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date	of dating		
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetel death	3 ☐Ectopic 5 ☐ Other					Moni		Day	Year
_	t the de by the a	ysic	1 Yes 2 No	9□ Unknown	t time or doubt	3 🖸 0 (1101	specify			-				
P.O.	requires that the death een signed by the atter hould be detached for u	P	Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying	cause give	n in Part I.	23e. D	d tobacco	use contril	oute to th	ne cause of	death?
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H	Th pag	S							1 ☐ Ye	nformed?		ath? ⊒ Yes	2 No	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						eath (Check on	ly one)				
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0			27. Manper of Death  1分 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		ime of	28c. Injury Work	at ?	28d. Describ	e how inju	nry occurre	d		
<u>.</u>	Attending r death. sctor: Atterby the fune	atic	2 Accident investigat			М	1 🗆 Y	es 2 □ No						
Division of Vital Records,	r Atta	tiflo	3 Suicide 6 Could not determine	28e. Place of In	ury - At home, far ic. (Specify)	m, street, fact	ory, office		28f. Location City or	o (Street a		r or Rura	l Route Nur	mber,
Ö	To the Hospital or Attandwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:												
	Hospital		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best	of my knowledge,	, death occurr	ed at the time	e, date and pla	ce, and due to t	ne cause(	s) and man	ner as si	ated.	-1
	n 24 n 24 ne Fu	Medical	one)	aminer: On the basis of and manner st	ated.	Dor investigati	on, in my op	mion, death oc	curred at the tim	ie, date ar	io piace, ar	na aue to	tne cause	(S)
	To the within To the Comp	Ž	29b. Signature and title of certifier	0		:	29c. License	number		29d. D	ate signed	(Month,	Day, Year)	
	_		panishe	Bahl,1	MD		D00.	5891	3 .	MA	4 0	7	2006	1 .
			30. Name and address of person wh	o completed cause of	death (Item 23a) (	Type, Print)		12000	12 A1	17-	1/6	711	RAN	FN
			MANISHA BA	HL, MD	GOOD.	SAM AT	217AN	MOST	BAL,	CTIM	00 =	M	ARYI	AND
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DOC-99-057    South Secretary Number   South Mark   South		Examin	er		_						Deam		40. Count	y or Death	
The state of the s				5. Social Security No	umber 6.	Sex	7. Age (In yrs.		If Under 1 Ye	ar If Under 2	24 Hrs. 8 Min.	B. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
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FFEMALE:   23c. If yes, outcome of pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live brith   2   Fetal death   3   Ectopic pregnancy   1   Live   2   No   3   Probably   4   Anknown   2   No   No   Probably   4   Anknown   2   No   No   Probably   4   Anknown   2   No   No   Probably   4   Anknown   2   No   No   Probably   4   Anknown   2   No   No   Probably   4   Anknown   2   No   No   Probably   4   No   No   No   No   No   No   No	÷(	/Medical Examiner	caminer	Immediate Cause (disease or condition resulting in death)  Sequentially list configures. Enter Unde Cause (Disease or that initiated events	Final n nditions, mediate rlying injury	a	(or as a consector as	quence of):							Onset and Death
1   Yes   2   No   3   Probably   4   Minknown   24a. Was an autopsy performed of death?   1   Yes   2   No   3   Probably   4   Minknown   24a. Was an autopsy performed of death?   1   Yes   2   No	2/C 8760.	ate be ex hysician the burial	cal	, and a second of		d	(OI as a collise	quence or).							
Compared to the control of the con	Box X	the death certific the attending p	ysician/Me	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐	months?	1 ☐ Live b 4 ☐ Pregr	oirth 2 Fet nant at time of	al death 3							•
The state of the property of t		88 PB 99	by	Part II. Other signif	icant conditions	s contributing to d	eath but not re	sulting in the u	nderlying cause	given in Part I.					7-4
The state of the property of t	MIT	The law requate has been bage 2 should	complete									autops	y ned?	prior to co death?	mpletion of cause of
The state of light of the state	Zita Vita	ician: sertifica	Be	examiner?		Hospital:								chro	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas 1+. Powell 10/ W. Read St., Balto. 2/20/  State 31. Date filed (Month, Day, Year)  A 2000 A	1	Phys or this oral dir				111		28b. Time o	nt 3□ DOA f 28c. lr	4 □ Nu					Hospice
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas 1+. Powell 10/ W. Read St., Balto. 2/20/  State 31. Date filed (Month, Day, Year)  A 2000 A	7/2	ath. or: Afte	atlor	2 Accident	investigat	ion	th, Day Year)	Injury			No				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas 1+. Powell 10/ W. Read St., Balto. 2/20/  State 31. Date filed (Month, Day, Year)  A 2000 A	ON B Divis	tal or Atta s after de al Diracto ed in by th	Certific			286. Place	of Injury - At I ing, etc. (Spec	nome, farm, st ify)	eet, factory, offi	СӨ	28			ber or Run	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas 1+. Powell 101 W. Read 5+, Balto. 2/201  State 31. Date filed (Month, Day, Year) / 32. Registrar's Signature	0	na Hospl 24 hour 16 Funer detely fill		(Check only		aminer: On the b	asis of examin								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas 1+ Powell 101 W. Read 5+, Balto. 2/201  State 31. Date filed (Month, Day, Year) / 32. Registrar's Signature		To the within To the comp	Ž	29b. Signature and	title of certifier				29c. Lic						
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Registrar				31. Date tiled (Mon	8 2004	32. F	Registrar's Sign	nature	books	,		1	,		

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	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  Robert Gerald Murphy  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	14 10	Year 4,200 Ic. County of Dec	4 070/2M
th	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 2 Months Days Hours Min. 3 Months Days Min. 3	of Birth th, Dey, Yea	NA 9. Bi	rthplace (State or Foreign country) 'H
imo	the Maryland 28a-f ehow	ector	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   Baltimore   Baltimore   10f. Zip Code   10f. Zip			10d. Inside City Limits 1 ☐ Yes 2 ☒No
1 rphy, 7 5-0036	er death with Items 23a or er munt Ge	d by Funeral Director	10e. Street and Number  8400 Park Heights Ave.  11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  10f. Zip Code  21208  11. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☒ No Specify:		USA  14. Race - Am Black, Wh.  Specify: W	erican Indian, ite, etc.
1 UV	d within giene. or than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Priest	16b.	Kind of Business	
Maryland	be file d oth	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route f	dersor	1	Zip Code)
altimore. Ma	Heal Heal tom other		Rev. Thomas Burke/Provincial 8400 Park Heights Ave. Fa  20a. Method of Disposition 1 Date Place of Disposition 2 Date Place of Disposition 2 Date Place of Disposition 3 Removal from State Baltimore Washington 2007		ce, MD 2 Location - City or	
- Baltin	permit. Pages Department of Important: If i eny injury or 2052.		21. Signature of Funda Succession Si		aurel, y Valle MD 2109	
8760	Physician /Medical Examiner  the prial-transit	Ilcal Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ory arrest,		Approximate Interval Between Onset and Death
P.O. Box 6	that the death certificated by the attending placed for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	livery Day Year
ords. P	w requires that the bear signed by should be detact	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e.	Did tobacco		the cause of death?
tal Rec	Physician: The law in this certificate has board director, page 2 st		101		prior to death?	utopsy findings available completion of cause of
Division of Vital Records.	or Attanding Physician: The law requires that the death certificate be executed flor death.  Iter death.  Diractor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Home 5 Nursing	Residence	ury occurred  nd Number or Re	cify) ural Route Number,
٥	the Hospital or in 24 hours after the Funaral Displetely filled in	ledical Cer	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to an and manner stated.	time, date an	nd place, and due	to the cause(s)
•	Nim With Common		29b. Signature and title of certifier  29c. License number  30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)  Vi as R. Hegge, M. 32i N Estous St, Suite 30  31. Date filed (Month, Day, Year)  32. Registrates Signature	29d. Da	Baltim	m. Dey. Year)  MD 2 (20)
•	To the Hospita within 24 hours within 6 Funaral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the manner stated.  29b. Signature and title of certifier  29c. License number  30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)  When R. Hegge, M. Salin St. Success St.	o the cause(s time, date an 29d. Da	s) and manner as nd place, and due	h, Dey, Year)

		-	For State Registrar	State of	f Marylan		artment of F				ene g. No. 2 (	004	15776
	Physicia	an	Decedent's Name (First, Middle	John F.	Mangum	TTT			2.	Date of Death Month May	Dav	2004	3. Time of Death 1:25 A. M
	/Medic Examin		4a. Facility Name (If not institution			111	4b. City, Town, o	r Location o	of Death	,		ty of Death	1.23 110
	Examin	eı	Anne Arundel	-			Annapo	olis			Ann	e Aru	nde1
	Funeral Director		5. Social Security Number 218 42 9198	6. Sex 1 <b>½</b> M 2□ F	7. Age ( <i>In yr</i> s 58	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min	Date of Birth (Month, Day, 19.	<sup>Y</sup> 945	9. Birthp Cour Mai	place (State or Foreign otry) cyland
	yland how		Usual Residence of Decedent  10a. State 10b. County		1	y, Town or Lo						1	0d. Inside City Limits
	Ba-fs	cto	7	Arundel	I	Davids	onville						1 ☐ Yes 2 No
	with th	Directo	10e. Street and Number	rach Farm	Court		10f. Zip Code 210	135		10	ig. Citizen of U.S		ntry?
	ns 23	Funeral	11, Marital Status		edent Ever in U.	.S. 13.			igin? (Specify	y Yes or No-		ace - Americ	can Indian,
220	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. A chief then "neturel", or items 23e or 28e-f show event. It is Madical Examinar must be notified at	by	1 □ Never Married 2 □ Marriad 3 □ Widowed 4 🏖 Divorced	Armed Fo ned 1 ⊠Yes	rces?	ŀ	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 215 No	an, Mexicar Specify:		án, etc.)	Spec.	ack, White, ify: Whi	
5	72 hou	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation	st of working	1	6b. Kind of	Business/In	dustry
7	within ne.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	kind of work done DO NOT use retired Plant	opera			Anne	Arund	lel County
V	filed v Hygie other t	e Co	12th 17. Father's Name (First, Middle,	Last)	<del></del>	110002				First, Middle, M			
	m = 9 %	To Be		F. Mangum	Jr.	10b Maili	ng Address (Street		Isabe	el Pachi	myer		a Code)
<u>8</u>	id 2 st lth and 27 Is n		Charles Mangu		er		Townsend						d 21225
ה ה	s 1 an f Heal item 2		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place	ce)	Date	2	Oc. Location	- City or To	own, State
2	Page nent o nnt: If iry or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		State		Crematory		5/19/2	004	B <b>alti</b> m	nore,	Maryland
Dallimo	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic events.		21. Signature of Funeral Service	Licensee	ush		2. Name and Addre						e, P.A. yland 21225
	Physician /Medical Examiner	10	23a. Fart1. Enter the disea a shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	aDue to b.	()	uence of):		ng, such as	cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
08/00,	fficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jesus of Jury that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
.O. BOX	the death certificate by the attending phys ached for use as the	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregna wirth 2 Peta lant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	4				ate of delive	ery Day Year
cords, r	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	inderlying cause giv	en in Part I	l. 	23e. Did tob	12		ne cause of death?
Ě	i: The law rei icate has bee r, page 2 sho	Completed	Obouty							24a. Was an autopsy perform	ed?	prior to co death?	psy findings available mpletion of cause of
IIai	ysicien: iis certifica director, j	Be C	25. Was case referred to medica examiner?		,				e of Death (C	Check only one	)		
on or v	ng Ph ifter th	ion: To	1 Yes 2 No  27 Manner of Death  Natural 5 Pendir	28a. ate (Mon	Inpatient 2 Injury th, Day Year)	28b. Time of Injury	f 28c. Injur Wor	4 LINE	280	5 Resider			y)
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	nined 288. Place	of Injury - At hong, etc. (Specif		reet, factory, office			Location (Str. City or Town,	eet and Num State)	nber or Rura	d Route Number,
	e Hospita 24 hours e Funerel etely filled	edical C		ng Physician: To the Examiner: On the b and man									
	To thi within To the	Me	29b. Signature and title of pertific	or Ma			29c. Licens	e number	, -	29	d. Date sign	ed (Montil).	Day, Year)
	1 4		· Cham	1	MO	)	D	55	18	+	5/1	5/0	4
	(x)		30. Name and andress of person	who completed caus	se of death (Item	п 23а) (Туре,	Print)	A	del	Med	lica	Ca	nter
**	Sta Registi		31. Date filed (Month, Day, Year,	Server Server	legistrar's Signa	dure de	rocks						

			For State Registrar	State of Maryla	and / Depa	artment of rtificate of	Health and I		iene2 0 0 4	15777
Ī	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last Eim I L Y 4a. Facility Name (If not institution, give	e street and number)		R GAN 4b. City, Town,	or Location of Death	2. Date of Deal Month	Day Year 15 200 4c. County of Deat	<u> </u>
	Funeral Director		216-16-6749		rs. last birthday,	Randall If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 11-26-1		e hplace (State or Foreign untry)
	h the Maryland r 28a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           Md         Baltimo           10e. Street and Number		City, Town or L			1	0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2X No
980	within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Madical Esta of ser count be notified at	by Funeral	417 Upland Road  11. Marital Status  1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	n U.S. 13.	2120 Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	USA  14. Race - Ame Black, White Specify:	
Maryland 21215-0036	within plene. r then '	Completed	15. Decedent's Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	edent's Usual Occu e kind of work done DO NOT use retin	eduring most of wor ed)	king	Own Home	Industry
laryland	should be and Mental smarked c	To Be	17. Father's Name (First, Middle, Last, John Whittington  19a. Informant's Name/Relationship (	Lips	19b. Mail	ing Address (Stree	Ethel Ma	rie Cath	erine McCa City or Town, State, 2	
Baltimore, M	1 an Heal		Elizabeth Morgan  20a. Method of Disposition  1 XBurial 2 Cremation 3 C  4 Donation 5 Other (Specif	Removal from State	<ul> <li>b. Place of Disp cemetery, cre</li> </ul>	osition (Name of matory or other pl	асө)	Date	36 20c. Location - City or ikesville,	
Balti	permit. Pages Department of I Important: If Ite any injury or of		21. Signature of Fun ry Service Lice	389:	2	2. Name and Add Eline Fur	ess of Facility	11824 R Reister	eisterstow stown Md 2	n Road
760,	death certificate be executed  Was a strength of the service of a strength of the service of the	icai Examiner	23a. Part.1. Enter the disease, or commodiate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ocar sequence of): re A sequence of).		Infar			Intervat Between Onset and Death
.O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ②No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of del Month	ivery Day Year
Records, P	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant conditions of	contributing to death but not	resulting in the t	underlying cause g	iven in Part I.		bacco use contribute to	othe cause of death?
tal Rec	iician: The law i certificate has bi rector, page 2 sh	e Completed	25. Was case referred to medical				26 Place of Dec	24a. Was a autops perform 1 Yes	red? prior to death? 2 ▼No 1 ☐ Yes	itopsy findings available completion of cause of
ion of Vital	ng Phys Iter this	ToB	examiner?  1 Yes 2 M No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio		ence 6 Other (Spec	oify)				
Division	pital or Attendi urs after death. erel Director: A	i Certification;	3 Suicide 6 Could not be determined	building, etc. (Sp	ecify)		k	City or Town		
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in 1	Medical		nysician: To the best of my miner: On the basis of exar and manner stated.	nination and/or in	nvestigation, in my	opinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
	1	2	30. Name and address of person who Srephen Siegel	completed cause of death	(Item 23a) (Type	Print) Reis	torston	~ MD	5/15/04 21136	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 8 2004	32. Registrar's S	ignature L	outs	-			

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	irtment of F tificate of		, ,	leg. No. 2 A A	15770
		Decedent's Name (First, Midd	die, Last)				2. Date of Dea Month		3. Time of Death
Physicia /Medic		OTIS EARL	MACE				Kern	12 ZOC	4 2:10 AM
Examin	er	4a. Facility Name (If not institution GILCHRIST CE			4b. City, Town, o	r Location of Death		4c. County of De	
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		irthplace (State or Foreign Country)
Director		217-09-0707	1 <b>⊠</b> M 2□F	95 Yrs.	WOMIS Days	riours latin.		/1908 MA	
yland Iow		Usual Residence of Decedent  10a. State 10b. Count	ty	10c. City, Town or Loc	cation				10d. Inside City Limits
e Man	Director	MD BALT	TIMORE	PINE H	URST				1 Tes 2 No
with the		10e. Street and Number 13 McKIM AV	7 F		10f. Zip Code 2121	2		10g. Citizen of What ( USA	Country?
death ms 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13. V		lispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No-		nerican Indian,
s after	by Ful	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	arried 1 Tes 2 X	lo	Yes 2 No	Specify:	iicari, etc.)	G	HITE
72 hours after death with the Marylar "neturel", or items 23e or 28e-1 show strat Examination in the maillied at		15. Decede	ent's Education		lent's Usual Occup			16b. Kind of Busines	
ithin 72 ie. ien "ne	Completed	(Specify only high Elementary/Secondary (0-12)		+) life. L	OO NOT use retire	•			ac cinten
be filed within 72 hours after death with the Maryland ital Hygiene. id other then "neturel", or flems 23e or 28e-f show event, the Marylad Examitted at event, the Marylad Examitted.	e Cor	17. Father's Name (First, Middle	4YRS	ELE	CTRICAL	CONTRAC		ELECTRIC  Maiden Sumame)	CO. OWNER
dental rked o	To Be	CHARLES ROS	SS MACE			SUSAN N	EWBOL	D TRUMP	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then 'eny injury or other treumetic event, Itia Magnes.		19a. Informant's Name/Relation						r, City or Town, State	, Zip Code) 204 •
1 and Health tem 27		20a. Method of Disposition	ESCARVER (G-1	20b. Place of Dispos	sition (Name of	Da	ate	20c. Location - City	
Pages nent of nt: If if		1 ☐ Burial 2 Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)		untory or other place UNT CRE		5/13/	2004 BAL	TO CITY MD
permit. Departn Importe eny inju		21. Signature of Funeral Service	ce Licensee	H	Name and Addre	ss of Facility JENKINS	& SO	NS CO.	
00 = 0 0	-	23a. Part1. Enter the disease,	or complications that caused	the death. Do not ente					Approximate
Physician		shock, or heart failure. Li Immediate Cause (Final	ist only one cause on each lin	in Dia 1	NEARRI	3011	, ,		Onset and Death
/Medical		disease or condition resulting in death)	a Due t (or as	a consequence of):		1000			UPOD S
Examiner	e	Sequentially list conditions, if any, leading to immediate	Oue to (or as	a consequence of):	reny (	riscase			7000
ecuted and transit	amine	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .=						
ia c	ŭ	resulting in death) Last		a consequence of):					
ficate b	edlca		d						
eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth		Ectopic pregnanc	,		23d. Date of d	
ne deat the att	Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown		Other (specify)			Month	Day Year
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	by Ph	Part II. Other significant condi	itions contributing to death b	ut not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
w requires been sign should be							1 🗆 Y	es 2□No 3	Probably 4 □Unknown
e taw n	ompleted						24a. Was a autop perfor	sy prior to	autopsy findings available completion of cause of
	e Coi	25. Was case referred to medic	cal			26. Place of Death	1 ☐ Yes	No 1□Ye	
d is d	To Be	examiner?	Hospital:	nt 2 ER/Outpatien	t 3 DOA Ott	A Company of the Comp			becity) Noop ice
Jing Ph J. After th funeral		27. Manner of Death		y Year) 28b. Time of Injury	28c. Injui Wor	yat 2 k? Yes 2 □ No	8d. Describe h	ow injury occurred	<del></del>
Attending r death. sctor: After	flcat	3 ☐ Suicide 6 ☐ Coul	mined 286. Place of I/I	ury - At home, farm, stre				treet and Number or	Aural Route Number,
tel or safter safter el Dire	Certification:	4 Homicide	building, etc	c. (Specify)			City or Tow	n, State)	
To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical		ying Physician: To the best on al Examiner: On the basis of and manner sta	examination and/or inv					
To the h within 2. To the I complet	Mec	29b. Signature and attle of certification	fier		29c. Licens			29d. Date signed (Mo	
1		Hera	nems		DS	8303	(	MAY 12	2004
6		30. Name and address of person	on who completed cause of d	eath (Item 23a) (Type	hope !	ST Balton	were v	asis as	4
Sta Registr		31. Date filed (Month, Day, Yea	ar) 32. Registra	ar's Signature					

DHMH 17 Rev 1/2001

			1 - State Registrar Amend Items 14,206	per Hi, 6831,0	5/18/6 Cer	tificate of l	ieaith an Death	ia Mentai H	ygiene Reg. No.	200	94	15779
ela	25		Decedent's Name (First, Middle, Last)					2. Date of I		Y	ear, / 3.	Time of Death
	Physici /Medic		Samiha			Nasse	er	٤.		L+ 6	74 -	+60 M"
	Examir	40	4a. Facility Name (If not institution, give street as			4b. City, Town, or Baltimo		Death	4c.	County of I	Death	
			Union Memorial Ho 5. Social Security Number 6. Sex	7. Age (In yrs. last)	hirthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of E	Rinth	9	Birthplace	(State or Foreign
	Funeral Director		N/A		Yrs.	Months Days		Min. (Month, I	Day, Year)	34	Country)	(State or Foreign
A.	7		Usual Residence of Decedent							*		
	show	<u>_</u>	10a. State 10b. County	10c. City, To								nside City Limits
	Ne Me	Director	MD NA	Balt	imo		-		10a Cit	izen of Wha		16-5 200 2 2 2 110
	death with the Maryland rms 23a or 28a-f show rmust be ricifiked at	D	10e. Street and Number			10f. Zip Code	110		Tog. Cit	U.S		
	Jeath	Funeral	3604 Greenmount Av	Decedent Ever in U.S.	13. \	Vas Decedent of H	218 ispanic Origin	? (Specify Yes or I	10-	14. Race -	American In	idian,
Maryland Z1Z15-0036	should be filed within 72 hours after death with the Marylan ad Mental Hygiene marked other than "naturel", or Items 23a or 28a-f show marked other than "naturel", or Items 23a or 28a-f show maric event, the Medical Examiner must be multiped at	by	1 Never Married 2 Married 1 If You	ed Forces? Yes 2X No es, Give ir or Dates:		Yes, specify Cuba  ☐ Yes 2 XNo	specify:	Puerto Hican, etc.)		Specify:	White, etc. White Bla	<del>ck</del>
בֿ ה	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade compi		(Give	ent's Usual Occupa	during most of	f working	16b. Ki	ind of Busin	ess/Industr	У
V	Aithin ne han	mple	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	life. L	OO NOT use retired	)			Home		
V	Hygie ther t		12th grade n  17. Father's Name (First, Middle, Last)	a	п.	ouse Wil		Name (First, Midd	le. Maiden			
and	ould be filed within Mental Hygiene Parked other than natic event, the Matic event, the Mentic event,	To Be	Abbas Nasser					, , , , , , , , , , , , , , , , , , , ,		,	Unk	nown
2	should ind Men ind marke umatic	F	19a. Informant's Name/Relationship (Type, Prin	<i>t)</i> 1:	9b. Mailin	g Address (Street a	and Number o	or Rural Route Nurr	ber, City o	r Town, Sta	ite, Zip Cod	e)
	~ ~ ~ ~		Imad Nasser-Son	3	604	Greenmo	ount A	Ave, Bal	timo	ore M	id 2	1218
ore,	of Health of Health fitem 27		20a. Method of Disposition  TV  Surial 2 ☐ Cremation 3 ☐ Removal	from State 20b. Place	of Dispo	sition (Name of natory or other place	e) 5/2	26/04 <sup>te</sup>	20c. Lo	cation - Cit	y or Town,	State
Ě	Pages ment of ant: If it		`4 Donation 5 ☐ Other (Specify)	Baal		k Cemet			Baal	lbeck	Le	banon
bailimore,	permit. Pages Department of Important: If it any injury or once		21. Signature of Funeral de vice Licens-	mh.		Name and Address arch F/1 300 Waba		t ve, Balt	imor	ce Mo	21	215
	<b>*</b>		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Deepn each line.							App	proximate rval Between
	Physician		Immediate Cause (Final disease or condition	ardiac	X	rest					Ons	set and Death
Ŋ.	/Medical Examiner		resulting in death)	e to (or as a consequence	ж p():	11/1/1:	17	vfarchin			21	V 20.
	- Adminior	-	Sequentially list conditions,	ue to (or as a consequence	e of):	10 cacasi	y xx	Wavering			7'	ici a(UII)
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	,								
<u>,</u>	cate be executed physicien and the burial-transit	Exa	that initiated events resulting in death) Last	ue to (or as a consequenc	e of):							
8/60,	te be lysicie	dical										
٥	ng ph	Med	IF FEMALE:									
POX	The law requires that the death certificate be executed tite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetel dea		Ectopic pregnancy			:	23d. Date of Month		Year
	that the death ed by the atte detached for	ysic	1 Vec 2 100	Pregnant at time of death Unknown	5∟	Other (specify)						
7. O	that the ed by detac	/ Ph	Part II. Other significant conditions contributing	g to death but not resulting	g in the ur	nderlying cause give	en in Part I.	23e. Dio	tobacco u	ise contribu	ite to the ca	use of death?
Vital Records,	w requires that been signed to should be det		100					1	Yes 2	□No 3	Probably	4 Unknown
S	aw rec	Completed						24a. Wt				indings available
ï	The lay	шо						per 1 Yes	opsy formed? 2 No	deat	th?	tion of cause of
g		BeC	25. Was case referred to medical examiner?				26. Place of	Death (Check only			-4	
	Physic this ce al direc	To	1 No Hospital	1 Inpatient	Outpatien		4   Nursi	ng Home 5 ☐ Re	sidence	6 □Other (	Specify)	
DIVISION OF	ing P		Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28t	o. Time of Injury	28c. Injury Work		28d. Describ	e how injur	y occurred		
<u>s</u>	tend death ttor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home,	larm etc		Yes 2 □No	281. Location	(Stroot an	d Number o	or Pural Pay	do Alumbar
2	after Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	, 10,111, 3(1)	set, ractory, office			own, State		or ridiar rioc	ne reamber,
	Hospita 14 hours Funeral	Medical C	29a. Certifier (Check only one)  Certifying Physician:  Check only one)	To the best of my knowled the basis of examination dimanner stated.	dge, death and/or inv	occurred at the time restigation, in my op	ne, date and p pinion, death	place, and due to the	e cause(s) e, date and	and manne place, and	er as stated.	cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	I mailler stated.		29c. License	e number		29d. Dat	e signed (A	Month, Day,	Year)
)	F 3 F 8		115/11/11/11	1 Mu		01	0054	1/03	H	au i	17 1	1004
	Ch		30. rame and oddress of person who complete	d cause of death (Item 23a			1	11 .11		1	/ 0	-001
			William JP F	rohre (	Inil	n Home	WING.	148-19-124				
j	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	6	1	1.11					
	Regist	el.	MAY 1 8 2004	General	D	DOOUR.	25					

				artment of Health and Mental rtificate of Death	Hygier	Z11110 15 (RH
			Decedent's Name (First, Middle, Last)	2. Date of Month	of Death	3. Time of Death
	Physicia /Medic		Clara Ellen Nelson	May		2004 12:37 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			205 Ardmore Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Linthicum  If Under 1 Year If Under 24 Hrs. 8. Date of		Anne Arundel  9. Birthplace (State or Foreign
	Funeral Director		236-44-1237 1 M 2 X F 69 Yrs.		Day Yea	935 West Virginia
	ס		Usual Residence of Decedent			
	anylan show	-	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M 28a-f	ecto	Maryland Anne Arundel Linthicum	1 10f. Zip Code	100.0	Citizen of What Country?
	with Sa or	Funeral Director	205 Ardmore Road	21090	US	
	ms 23	nera		Was Oecedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "naturel", or liems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Fur	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2☐ No Specify:	.)	Black, White, etc.  Specify: White
9	2 hou	ted	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	Kind of Business/Industry
Maryland 21215-0036	e filed within 7 al Hygiene. i other than "n vent, the Med	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  (Giv. life. Sales	e kind of work done during most of working DO NOT use retired) S	Av	on Representative
ם 2	e filed Il Hygie other vent, L	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M.	iddle, Maid	en Sumame)
ylar	should be ind Mental marked o	70	William Walker Perry	Ellen Kaufma		
Mar	nd 2 sh ith and 27 is m traum			ing Address <i>(Street and Number or Rural Route N</i> Wyndham Court New P		ichey, FL 34655
e,	t and Health tem 27 other tr		20a Method of Disposition 20b. Place of Disp		-	Location - City or Town, State
e E	Pages nent of ant: If i		1 Buriai XV Cremation 3 Linemoval from State	rematory Inc. 5-17-04		Baltimore, MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any Injury or other 2002.		21. Signature of Funeral Scrivice License Edward A. Gregorchik	22. Name and Address of Facility Cremation Society of M 299 Frederick Road B	D. In altim	c. ore, MD 21228
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	JON- FIAM COL hu	NG (	A 15 ho 5
	/Medical Examiner		Due to (or as a consequence of):			
	, .	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events c			14
8760,	ate be executed obysician and the burial-transit	lical Ex	d d			
687	ificate g phys	edic	g			
.O. Box	at the death certificate by the attending phys tached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
٥	law requires that the as been signed by the 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacc	o use contribute to the cause of death?
ords	w require been sig should b				1 Pres	2 No 3 Probably 4 Unknown
Vital Records,	9 ~ e	Completed			Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ital	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death (Check of	nly one)	
of V	Physiclan: this certific ral director,	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			
	fter ne	Certification:	27. Manner of Death  1	of 28c. Injury at 28d. Desc Work? M 1 ☐ Yes 2 ☐ No	ribe now in	jury occurred
Division	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office 28f. Locat	ion (Street r Town, Sta	and Number or Rural Route Number,
Ö	rs afte al Dire	Cert	Homicide building, etc. (Specify)	City		210)
	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one)  1			
	To the To the comp	Ž	29b Signature and title of cartifier	29c. License number		Date signed (Month, Day, Year)  Jay 17, 2004
•	16		30. Name and address of person who completed cause of death (first 23a) (Type			6N - 100 C
			31. Date (iled (Month, Day, Year)  32. Registrar's Signature	TON HUE, JOHNA	ORE	, 713 , 31307
	Sta Regist	ate rar	MAY 1 8 2004 Brown 6			
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			For 1 State	State of M		d / Dep		of He	alth a		ntal Hyg	jiene	) () () () () ()	1 2	0.1
			Registrar	1			runcate	טוט	ealli		Date of Dea		004		10
Н	Physici	an	1. Decedent's Name (First, Middle, L	.ast)	NIX						Month	Day	Year	3. Time of D	
	/Media	cal	JOSEPH								MAY	11	2004		РМ
	Examir	ıer	4a. Facility Name (If not institution, g		7.6		4b. City, To			Death	i	4c. Cour	ity of Deati N/A	n	
			Ine Johns Hop  5. Social Security Number  6.			et hirthday	B/3-U		If Under 2	A Hrs o	Py of Birth				C/
	Funeral		220 08 6255	M 2□F	ge (In yrs. Ia 18	Yrs.	Months D		Hours	Min.	Date of Birth (Month, Day	1985	9. Birti	nplace (State or I unitry) 'Yland	-oreign
	Director		Usual Residence of Decedent							INC	. · · ·	1303	rial	yrana	
	land ow		10a. State 10b. County		10c. City	Town or L	ocation							10d. Inside City	Limits
	Many Lied	ţō	Maryland Baltin	nore	Ba	1timo	re							1 ☐ Yes 2	No.
	r 288	by Funeral Director	10e. Street and Number				10f. Zip Co	ode			1	0g. Citizen o	f What Co	untry?	
	3a o	D	1047 Grovehill	Road			2	1227	7			U.S	5.		
	ma 2	ner	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.	Was Decedent	t of Hisp	panic Orig	in? (Specify	Yes or No-			rican Indian,	
9	or ite	Ē	1X Never Married 2 ☐ Married	Armed Forces  1 ☐ Yes 2 ☑  If Yes, Give	r No	1	1 ☐ Yes 2 €			Pueno Ric	an, etc.)		ack, White		
03	ral',	i by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	:		TLI Yes ZE	1 NO	эреспу:			Spec	ify: Wh:	ıte	
21215-0036	within 72 hours after death with the Maryland ene. then *natural', or items 23s or 28s-1 show the Medical Exempter must be multised at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Dece	dent's Usual C kind of work of DO NOT use r	occupati	ion ring most	of working		16b. Kind of	Business/I	ndustry St	ore
21	ithin	ηpi	Elementary/Secondary (0-12)	College (1-4or	5+)	Cle		retired)				Lucky	s Coi	nvenienc	
	filed with Hygiene. other thei		12th				LK	1.							
pu	ba fill tal H d ott	Be	17. Father's Name (First, Middle, La Elma La					1				Maiden Suma Lelle (		11	
Maryland	should ba ind Mental markad c	ို				700									
Mar	2 short and raum		19a. Informant's Name/Relationship  E. Lee Nix /	Father			ng Address <i>(Si</i> Vena La		d Number	ror Rumal R Pasa	<sub>oute Numbei</sub> dena ,	r, City or Tow Maryla	n, State, Z and 2	ip Code) 1122	
	1 and Health em 27 ither tr				20h Bir				1	Date					
0	Pagas 1 nent of H int: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	CB	metery, cre	osition (Name i matory or othe	or place)	1-   E		4.0	20c. Location	-		آم مبسا
Ë	tmentant:		* 4 □ Donation 5 □ Other (Spec		GIE		en Mem.							e, Maryl	Land
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iteme 23e or 28e-1 show many injury or other traumatic event, the Medical Exemiter must be multiled at once.		21. Signature of Funeral Service Lice	20 umis	susk		2. Name and A 001 Rit							e, P.A. yland 2	1225
			23a. Part1. Enter the disease, or co	polications that cause one cause on each	d the death.	. Do not en	ter the mode o	f dying,	such as c	ardiac or re	spiratory arr	est,		Approximate Interval Betwe	en
	Priysician		Immediate Cause (Final disease or condition	B		D	th							Onset and De	ath
	/Medical		resulting in death)	a Due to (or as	s a consequ	ence of):	1 '1							Y	
н	Examiner		Convention by the conditions	Cara	tionu	Imor	aru	Ar	res	+				3 day	5
	D ==	ner	Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as	s a conseque	ence of):	1					100		1	
	te ba exacuted ysician and te burial-transit	Examiner	Cause (Disease or injury that initiated events	c. Eb s	stei	0.5	Ano	ma	4.4					18 yea	rs
ó,	a exe ian a urial-	E	resulting in death) Last	Due to (or as	s a consequ	ence of):			-4						
3760,	icate ba exacuted physician and s the burial-transit	lical		d									-		
<b>68</b>	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:												
Box	th ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	⊒Ectopic pregr	nancy				1	ate of deli-	very Day Yea	21
-	e des the al	Sici	1 🗆 Yes 2 🗆 No 9 🗆 Unknown	4□Pregnant a 9□Unknown	at time of dea	ath 5	Other (specif	fy)					OHIII	Day	21
P.O.	d by etacl	Phy		Lagrania de docta l		Mina in the			in Dead I		One Did to		ntaile stanta	the serves of de-	
	res tha igned b	by	Part II. Other significant conditions	contributing to death i	out not resul	iting in the u	nderlying caus	se given	in Part I.					the cause of dea	
Records,	w require been sign should b	Completed								_	1 □ Ye	s 2 No	3   110	bably 4 🗆 Unk	
ec	law lasb	ple									24a. Was a autops	V	prior to o	opsy findings ava	ailable se of
<u> </u>	ysician: The law is certificate has b director, page 2 s	Con									perform	ned?	death? 1 ☐ Yes	2 No	
Vital	Physician: this certificanal director, I	Be	25. Was case referred to medical examiner?	- 25						of Death (C	heck only on	e)			
of \	20 00	ပ္	1X Yes 2 □ No	Hospital: 1 Inpati		R/Outpatier		Other:	4   Nuis	sing Home	5 🗆 Reside	ence 6 🗆 O	ther (Spec	ify)	
ū	ding Ph h. After thi funeral	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury		Injury a Work?			. Describe ho	w injury occu	irred		
sio	Attanding or death. actor: After by the fune	cati	2 Accident investigat 3 Suicide 6 Could not	he			М		s 2 🗆 N						
Division	l or Attano after death Diractor: I in by the	Certification:	4 Homicide determine	286. Place of in	ijury - At hor tc. <i>(Specify)</i>	ne, farm, sti	reet, factory, of	ffice		28f.	Location (St City or Town	reet and Nun n, State)	ber or Ru	ral Route Numbe	<i>T</i> ,
Ω	urs at		7												
	To the Hospital or At within 24 hours after of To the Funeral Direct cumpletely filled in by	Medical	29a. Certifier (Check only one)  1X Certifying i	Physician: To the best aminer: On the basis of and manner s	of examination	rledge, deat on and/or in	h occurred at ti vestigation, in	he time, my opin	, date and nion, death	place, and occurred a	due to the ca at the time, da	ause(s) and nate and place	nanner as , and due	stated. to the cause(s)	
	o the	Med	29b. Signature and title of certifier	und marinor s			29c. Li	icense n	number		2	9d. Date sign	ed (Month	Day, Year)	
	->-0		mile No	illed 1:			g	= (	- 00	20		n Av	()	20211	
	Ĺ		30. Name and address of person wh	o completed cause of	death (Item	23a) (Tvoe		<u> </u>				· M Y	11,	2004	
	5		Mirale Still	frim	6 c	A	ORTH	V-N	PL	STR	EET	BALT	181/00	MO R	
	Sta	ite	31. Date filed (Month, Day, Year)	Charles Inc.	rar's Signatu			TO U	- L.Y.				- LAN	110	
	Registi		MAY 1 8 20	04 Sine	va	5	Soon	ري	-						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 5. 04 5:15 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number 4c. County of Death Examiner If Under 24 Hrs. a Der ickers BALTO. BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days 1 ☐ M 2 💢 F 220-14-6724 81 Director May 26, 1922 Maryland Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mertel Hygiene.
Int: If item 27 is marked other than "naturel", or items 23a or 28e-f show mit: If item 27 is marked other than "naturel", or other traumatic event, the Medical Expansion must be notified at any or other traumatic event, the Medical Expansion must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Towson Directo 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21204 615 Chestnut Ave. United States Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White ģ 3 Widowed 4 □ Divorced Year or Detes Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) John Hunt Sifford Agnes Harrison Dunkel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garland, TX James Edward O'Connor/son 4108 Towngate Blvd. 75041 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Depertment of H important: if its any injury or ot once. cemetery, cremetory or other place 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/18/04 Greenmount crematory Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. 21. Signature of Funeral Service Licensee 21212 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical MYDEARDIAL INFARCTION ader Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Munner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier th. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number nd eddress of person who completed cause of death (fem 23a) (Type, Print BAUTIMURG M DHY MO 6701 CHARLES N 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 8 2004 Registrar

			Pleas  1 - For State Registrar	State of M		Depa		f Health a	and Ment	al Hygi	_		15783
1	Physicia /Medic		1. Decedent's Name (First, Middle, Anne Eliza	beth Purga					M	ate of Death anth	13° à	Pod4	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, Stella Maris Ho	•				n, or Location o imore	of Death	1	4c. County	of Death	
Ī	Funeral Director		218-48-0176	5. Sex 7. Ag 1 □ M 2 F	e (In yrs. last b 91	irthday) Yrs.	If Under 1 You Months Da		24 Hrs. 8. Da Min. (M Ma.)	te of Birth lonth, Day, 30,	<sup>Year)</sup> 1913	9. Birthpl Coun Mary	ace (State or Foreign try) rland
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	ocation					10	Od. Inside City Limits
	Ba-f st	ector	Maryland Balti	more	Du	ında:				1 40	0.00		1 □Yes 2XQNNo
	3a or 2	i Dire	10e. Street and Number 3010 Dunmurry R	oad			10f. Zip Cod	e 222			og. Citizen of v United		
136	be filed within 72 hours after death with the Maryland Hygiene.  do cher than "naturat; or Itams 23a or 28a-f show evant, the Medical Examinar must be notified at	by Funeral Directo	11. Marital Status  1 Never Married 2 Marrie 3 Midowed 4 Divorced	12. Was Decedent Armed Forces?	,			of Hispanic Ori Cuban, Mexican	gin? (Specify Y n, Puerto Rican		14. Rad	ck, White,	an Indian,
31215-0036	nin 72 hou In "natura Medical E	Completed by	15. Decedent' (Specify only highest	s Education grade completed)	5.1	(Give life.	dent's Usual Oo kind of work do DO NOT use re	ne during mos tired)	t of working	1	6b. Kind of B		•
	be filed within ital Hygiene. Id other than "evant, the Me	Com	Elementary/Secondary (0-12)	1		Tead	cher's		er's Name (First	t Middle M		oling	<u> </u>
Maryland	ould be fil Mental H arkad oti atic evar	To Be	17. Father's Name (First, Middle, L Charles Moris	Webb				Anni			alden Suman	ne)	
Mary	and and is m		19a. Informant's Name/Relationsh Anne Benson - Da		La Contraction		ng Address <i>(Sti</i> Darnle		er or Rural Rous Woodby		City or Town, Virgi		
ē,	es 1 and of Health of itam 27 or other to		20a. Method of Disposition		20b. Place	of Dispo	sition (Name o	1 1	Date	-	Oc. Location		
Baltimore,	Pages Iment of tant: If it		1 Burial 2 □ Cremation  1 Donation 5 □ Other (Sp	3 ∐Removal from State ecify) ————————————————————————————————————		wn (	Cemeter	У	5/19/04				Maryland
Bail	permit. Pages Department of Important: If it any injury or o		21. Signatura of Fur eray Spring	What M	01142	B1	adley ^ 134 wil	Ashton low Spr	Matthew ing Roa	s Funda	eral H ndalk,	lome, Mary	Inc. land 21222
l,		0	28a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused inly one cause on each li	d the death. Do	not ent	ter the mode of	dying, such as	cardiac or resp	iratory arre	st,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	a consequence	CCu e of):	57	care	<i>r</i>				
4	P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Dispared of Figure )	b. Due to (or as	a consequence	∋ of):							
,09	e be executed sician and e burial-transit	al Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	∍ of):							- U 1000 V
.O. Box 68	The law requires that the death certificate ite has been signed by the attending physicage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat		⊒Ectopic pregn. ] Other (s <i>pecif</i> y					te of delive	ry Day Year
۵.	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditio	ns contributing to death t	out not resulting	in the u	nderlying cause	given in Part I.	. 2	3e. Did tob 1 ☐ Ye	_/		e cause of death?
l Records,	The law require ate has been siç page 2 should b	Completed								4a. Was an autopsy perform ☐ Yes 2	ed?	Were autor prior to con death? 1 \( \text{Yes}	osy findings available inpletion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			45.004	Other	of Death (Che				
Division of Vital	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da		Time o Injury	f 28c.	Injury at Work? 1 Pes 2			w injury occur		Nospice
DIVIS	s after des s after des al Diractor ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 200. Flace of in	jury - At home, tc. (Specify)	farm, sti	reet, factory, of	ice		ocation (Str ity or Town,		er or Rural	Route Number,
	Hospit 24 hour Funara etely fills	edical		Physicien: To the best exeminer: On the basis of and manner st	of examination a								
	To the within To the comple	Me	29b. Signature and title of certifier	\ \ \ \ .			29c. Lie	cense number		29	d. Date signe	d (Month, L	Day, Year)
•	1	>	▶ AY \	to complaint source of	death (Itam 00-	\ /Tunn	D)	10854		10.0	5/1	7/20	707
			30. Name and address of person v	2. sohom	301	5 (Type.	T PAL	or pr	· Ba	Lin	ove v	nd.	20212
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 8	327 Regist	rar's Signature	Spi	will						

			State of Maryla  State of Maryla  Registrer	ind / Depa	artment of Health ar	nd Mental Hygi	iene 2004	15784
			Decedent's Name (First, Middle, Last)			2. Date of Deat	h	3. Time of Death
	Physicia		Virginia Page Pete	rs		May 17,	Day Year 2004	11:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		4c. County of Deat	
			Fairhaven Nursing Home		Sykesvil		Carro	
	Funeral		104 257 5	rs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Min. (Month, Day,	Yeer) 9. Birtl	hplace (State or Foreign ountry)
	Director		217-09-0969   1   93	Yrs.		SEP 11,	1910 Ma:	ryland
	land			City, Town or Lo	cation			10d. Inside City Limits
	Mary -f sh	ţō	Maryland Carroll		Sykesville			1 ☐ Yes 2X No
	r 288	lrec	10e. Street and Number		10f. Zip Code	16	g. Citizen of What Co	ountry?
	th will	Funeral Director	7200 Third Avenue, HC117		21784		USA	
	r dea	Iner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Origi f Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. then "ratural", or itame 23a or 28a-f show fra Modical Exemitier most be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 14 ☐ Sivorced 1 ☐ Yes 7 ☐ Parried 1 ☐ Yes 1 ☒ Widowed 4 ☐ Divorced 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 1 ☐ Yes 2 ☒ No If Yes 2 ☐		1 ☐ Yes 🌠 No Specify:		Specify: W]	hite
Ş	hour		3 X Widowed 4 Divorced Year or Dates:  15. Decedent's Education	16a, Decer	dent's Usual Occupation		16b. Kind of Business/	Industry
5	n "na	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of DO NOT use retired)	of working		,
212	d with giene ar the	E O	12	Home	maker		Own Ho	ome
5	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or litame 23a or 28a-1 show event. Its Macilcal Examinations is a resist to notified at	Bec	17. Father's Name (First, Middle, Last)		18. Mother	s Name (First, Middle, M	laiden Sumame)	
yla	2 should be filed volume and Mental Hygie Is marked other traumatic event, III	2	Wesley Witwright Sellma			ginia Don		
Maryland 21215-0036	12 sh and 1s m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number		,	/
e,	1 and Health em 2 ther 1		Virginia Arndt/Daughter  20a. Method of Disposition   20b	. Place of Dispo	O Asbury Circle		O SOLOMONS  Oc. Location - City or	
Ö	ages int of t: If It		1 Burial 2 Cremation 3 Removal from State	cemetery, cren	natory or other place)		•	
Baltimore,	nit. Partme		21 Signature of Funeral Service Ligensee	tro Crei	matory, Inc. 5. Name and Address of Facility	/10/04	Baltimore	e, MD
B	permil. Pages 1 and 2 should be Department of Heaith and Menta Important: If Item 27 Is marked any Injury or other traumatic es		Edward A. Gregorchik	C 2	Name and Address of Facility remation Soc 99 Frederick	iety of M	D, Inc.	MD 21228
			23a. Part1. Enter the disease, or complications that caused the de	eath. Do not ent	er the mode of dying, such as c	ardiac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- In 6	Part Den	nonfic		Onset and Death
	/Medical		resulting in death)  Due to (or as a const					3 / / -
	Examiner		Sequentially list conditions, b.					
	ed isit	line	if any, leading to immediate Due to (or as a consicuse). Enter Undertying Cause (Disease or injury	equence or):				
	ai-trar	Examiner	that initiated events c	equence of):				
8760,	icate be executed physician and s the burial-transit	dical E						
9	tificat ig phy as the	ledi						
Вох	death certifica attending pl	ician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fe		Ectopic pregnancy		23d. Date of deli	,
	ne dea the att hed fo	sici	in the past 12 months? 1 □ Yes 2 Mo 4 □ Pregnant at time of 9 □ Unknown 9 □ Unknown		Other (specify)		Month	Day Year
P.0	that the de ed by the detached	Physi	Part II. Other significant conditions contributing to death but not r	resulting in the u	nderlying cause given in Part I	23e. Did tob	acco use contribute to	the cause of death?
ds,	Se Lg 9	d by	Disbet. Melli		naony ng oadac gronnin ann			obably 4 Unknown
20	w require been sign	Completed				24a. Was ar	24h Were au	itopsy findings available
Re	The lav	ф			*****	autopsy perform	/ prior to c	completion of cause of
ta		O	25. Was case relerred to medical		26. Place of	1 ☐ Yes 2 of Death (Check only one		2□ No
Ξ	\$ S	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	24	sing Home 5 Reside		cify)
0	ng Ph fter th ineral	:uo	27. Manuer of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	Work?	28d. Describe ho	w injury occurred	
Sio	Attending or death. ector: After by the fune	catl	2 Accident investigation		M 1 Yes 2 N			
Division of Vital Records,	or At after of Direction by	Certification;	4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	: nome, tarm, str icify)	eet, factory, office	City or Town	eet and Number or Ru , State)	irai Houte Number,
1	Hospital		29a. Certifier 11 Certifying Physicien: To the best of my k	(nowledge, deat	h occurred at the time, date and	place, and due to the ca	use(s) and manner as	stated.
	To the Hospital or Attending I within 24 hours after death. To tha Funeral Director: After completely filled in by the funer	edicai	(Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.	ination and/or in	vestigation, in my opinion, death	occurred at the time, da	ite and place, and due	to the cause(s)
	To the within 2 To tha complete	Me	29b. Signature and title ol certifier	1-10	29c. License number	29	ld. Date signed (Month	h, Day, Year)
)	×		Park J. M.	UN U	Uslos		May 18, 2	2004
	10		30. Name and address of person who completed cause of death (II	tem 23a) (Type,	29c. License number  07289  Prigt)  Coach	orte Os	Reich	for Miluse
	Sta Registi		31. Date liled (Month, Day, Year)  MAY 1 8 2004  32. Registrar's Sig	inature de	parks			

			1 - For State Registrar	State of M	aryland /		artment of H			, ,	jiene	200	1 [	15785
			Decedent's Name (First, Middle, La			2. Date of Dea	Death 3. Time of Death							
	Physici		Charles J. H	ittas					м	Month av	Day 14		04 8	:50 P. M
	/Medic Examin		4a. Fecility Name (If not institution, giv		)		4b. City, Town, or	r Location o		<u>~</u>		County of E		130 11
			6 Berlee Court				Winds	or Mi	11			Balti	more	
	Funeral		5. Social Security Number 6. S		ge (In yrs. last b	irthday)	If Under 1 Year Months Days			B. Date of Birth (Month, Day	1			(State or Foreign
	Director		160-34-8675	<b>⊠</b> M 2□ F	63	Yrs.	Michinis Buys	110015		May 3,		1	PA	
	pur 🛦 :		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	ecation						10d In	nside City Limits
	shor	5	Too. County		Toc. City, To	WIT OF EC	Callon						1	Yes 2 No
	he №	ect	MD Baltin 10e. Street and Number	nore	Wi	ndsc	or Mill				0.00			
	with I	늅	Toe. Street and Number				10f. Zip Code			'		zen of Wha	t Country?	
	eath	Funeral Director	6 Berlee Court	12. Was Decedent	Ever in 11 S	12.1		21244		fu Vac ar No		USA	American In	dian
	Itam Itam Iner	Š	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Amed Forces	?	13.	Was Decedent of H if Yes, specify Cuba	in, Mexican	n, Puerto Ri	can, etc.)			White, etc.	Ciari,
36	Ir, or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	140		1 ☐ Yes 2 🛣 No	Specity:				Specify:	Wh	ite
ğ	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-1 show ha Madical Examiner must be notified at	ed	15. Decedent's E	ducation	168	a. Deced	dent's Usual Occup	ation			16b. Kir	nd of Busine	ess/Industry	
75	n n Ned	Completed	(Specify only highest gra Elementary/Secondary (0-12)		5.1	(Give life. l	kind of work done o DO NOT use retired	during mosi 1)	t of working					
212	d with giene	E	11	College (1-4or	5+)	F	Foreman				Wi	re Fa	ctory	
ğ	othe	Bec	17. Father's Name (First, Middle, Last					18. Mothe	er's Name (	First, Middle, I				
<u>a</u>	lid be Venta rked	To B	Emmanuel Pittas	3				UIIKIIO	WII					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic svent, the Medical Examiner mast be notified at ance.	_	19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailir	ng Address (Street	and Numbe	er or Rural I	Route Number	City or	Town, Sta	te, Zip Code	9)
	alth a alth a 27 ls		Frances Pittas/V	life		6 E	Berlee Co	urt	Balt	imore,	MD	21244		
Baltimore,	of Hei		20a. Method of Disposition		20b. Place o	of Dispo	sition (Name of natory or other place	(a)	Dat	10	20c. Lo	cation - City	or Town, S	State
E	Page not: If ry or		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Special				Mem. Pa		5/18/	2004	Syk	esvil	1e, M	ת
ä	mit. Dartin Sorta / Inju		21. Signature of Furferal Service Licer	1500	Dane	22	Name and Address	s of Eacilit	hv					
m	Depa tmpo any ir		Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Ave. Baltimore, MD 21228									•		
۳			23a. Part   Ent   the disease, or com	plications that cause	d the death. Do								Appi	roximate
	Physician	shock, or reart failure. List only one cause on each line.  Interediate Tuse (Final disease or condition  Con Control Turner (Least Fee Lune)									Onset ar			val Between et and Death
1,000	/Medical		disease or condition resulting in death)	a. Due to ras	a consequence	of):	7 (33	1010			-		no	rurs
	icate be executed xx x physician and in sthe burial-transit and x the b			Fluid	Fluid over load								10	44.
		Jer	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying	Due to (or as a consequence of):  Chronic Revel Feelure									مريد ا	7
		Examiner	Cause (Disease or injury that initiated events	ممد	el failure									
o,	an ar rial-tr	EX	resulting in death) Last	Due to (or as	a consequence	of);								
8760,	ate be executed hysician and the burial-transit	Physician/Medical		_ d										
9	∄ on a	Med	Ser service										1	
Вох	that the death certific ed by the attending p detached for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								2	23d. Date of delivery		
	ne deat the att hed fo	icis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)					Month	Day	Year
P.0	by the	hys	9 ☐ Unknown	9 Onknown										
s,	S C 0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of			use of death?	
2	w require been sig should b	be								1 □ Ye	s 2 🗆	2 No 3 Probably 4 Munknown		
Vital Record	aw re	Completed								24a. Wasa		24b. Were	autopsy fir	ndings available
æ	The law cate has page 2	E O								autops perform		death	h?	ion of cause of
ita	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death (6	Check only on			703 201	
<b>&gt;</b>	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2⊠No	Hospital: 1 ☐ Inpatio	ent 2 ER/O	utpatien	t 3□ DOA Othe	9r: 4 □ Nui	rsing Home	5 🗷 Reside	nce 6	Other (S	Specify)	
0 ر	g Ph ter th		27. Manner of Death	28a. Date of Inju		Time of	28c. Injury Work	at	28d. Describe ho					
0	Attending r death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investigation	1	, ,	,,		Yes 2□N	No					
Division	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of in	jury - At home, f	arm, stre	eet, factory, office		281	Location (Sti	reet and	Number o	r Rural Rout	te Number,
	s aft at Di ed in	Cer								-	. 0,010)			
	To the Hospital or within 24 hours afte To the Funeral Directional Completely filled in the Funeral Direction of the Fune	edical	29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis of	of my knowledg	e, death	occurred at the tim	e, date and	d place, and	d due to the ca	use(s)	and manner	r as stated.	
	the H in 24 the F plete	edi	one)	and manner st	ated.		restigation, in my of	omion, deal	in occurred	at the time, da	ate and	piace, and o	ane to the c	ause(s)
	To the Hospital or Attending Physwithin 24 hours attendeath. To the Funeral Director: After this completely filled in by the funeral directors.	Σ	29b. Signature and title of certifier	1			29c. License	-						Year)
•			1)	) , N	<b>YY</b> .		<i>y</i> 4	515	1		5/	1/1	٠, ٢	
	V		30. Name and address of person who		death (Item 23a)									
	i i		TIM O. MAUNG	516. 4.	POLLIN	9	hom)	Sute	107	CATO	NYV	ILLE	~ >	21228.
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 8 20!	32. Registr	rar's Signature	4	for it		/					

			1 - For Amend Item #18 per in 6331 5/18/04 tas Certificate of Deat	h and Mental	l Hygiene	2004	15706					
$\tilde{\lambda}_{i}$	es and		1. Decedent's Name (First, Middle, Last)	2. Date	Reg. No.		3. Time of Death					
	Physici /Medic		Clara BENTHA Flaknoy	Man		2004	1100 PM					
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		4c.	County of Death						
	Funeral	-	3. Coolal Coolal ( Cox		of Birth oth, Day, Year)	9. Birthp	place (State or Foreign					
%	Director	7	2/6 23 12 38 10 M 20 F 80 Yrs. Months Days Hour	irs Min. Och	31, 19	23 mm						
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	10d. Inside City Limits					
	e-f sh	ctor	Mary mo NA BNHANN				Yes 2□No					
	with th	Director	10e. Street and Number 10f. Zip Code	. <del>"</del> 9	10g. Citi	zen of What Cour	•					
	ns 236	erai	3 433 Muyfeld Ave  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic If Yes, specify Cuban, Mexit		or No-	14. Race - Americ						
98	ours after death with the Marylar ral', or Items 23a or 28e-f show Ext. other constitute to the	by Funeral	1 Never Married 2 Married 1 Yes 2 No Spec		tc.)	Black, White,	etc.					
5-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28e-f show to Modell Exercities Lost be coulfed at	ed p	3 ☐ Widowed Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b Ki	nd of Business/In	dustry					
215	hin 72 9. Notice	Completed	(Specify only highest grade completed)  (Give kind of work done during material life. DO NOT use retired)  (Give kind of work done during material life. DO NOT use retired)	most of working								
2	filed with Hygiene other than		134 grade MAIL SELTER	John of Bloom (First )			2 Service					
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other treumatic event, Ite Wasten 20029.	To Be	Edums Mark	lother's Name (First, I	_	ah Watkins	<b>:</b>					
ary	and Mark	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nur.		Number, City o	r Town, State, Zip	Code)					
-	t and the selfth om 27 liher tr	1	MARTIN FINKING 1502 5910 DAVIEW	CF BAIT	1	, Med o						
Baltimore	ages ant of H t: If ite y or of		20a. Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   1   Burial   2   Cremation   3   Removal from State     4   Donation   5   Other (Specify)	5/18/04		Cation - City or To	M./					
altir	permit. Pag Department Important: eny injury c		21. Signature of uneral Service Licensee 22. Name and Address of a	acility CINA TH	AN- 4	Byrle is	nest Hine					
B	Depa Impo eny it		21. Signature of Funeral Service Licensee  22. Name and Address of Fa  24. V KLISTE  BOLLAND. 1. M.S.	21315	Ce, 470							
			23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock or heaft failure. List only one cause on each line.  Immediate Cause (Final	ns that caused the death. Do not enter the mode of dying, such as cardiac or respirator, use on each line.								
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):			-	two weeks					
14	Examiner											
	te be executed ysician and ne burial-transit	iner	Sequentially list conditions, farly, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Use to (or till a consequence of):								
ς,		Examiner	that initiated events c. Pue to (or as a consequence of):			-						
3760,		cal	d									
x 68	sertifica ding pt se as ti	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy									
Вох	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1			3d. Date of delivery Month Day Year						
P.O.	by the	hys	9 ☐ Unknown									
	The law requires that the death certificate be exate has been signed by the attending physician bage 2 should be detached for use as the burial	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23e	. Did tobacco u 1 ☐ Yes 2 [		ne cause of death?					
Records,	w requ	Completed		24a	. Was an	1	psy findings available					
Re	sician: The law certificate has t lirector, page 2 s	omo		10	autopsy performed? Yes 2 No	prior to coo death? 1 \(\sum \text{Yes}\)	mpletion of cause of					
Vital	Physician: this certificanal director,	Be	examiner?	Place of Death (Check								
of	Physic rethis oral dir	To To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Nursing Home 5 28d. Des	Residence ( cribe how injur		()					
ion	Attending F ir death. ector: After by the funer	atior	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2									
Division	or Atte	rtific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	spital	ai Ce	29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date	e and place, and due	to the cause(s)	and manner as si	rated.					
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical Certification:	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, one) and manner stated.	death occurred at the	time, date and	place, and due to	the cause(s)					
	within To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Dat	e signed (Month,	Day, Year)					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	71	May	15,20	דטע					
	3		Mark Levis Department of Medicae Union Memoria	al Hospital.	Battime	ine Mary	land					
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	/								
	negisti	rai	sparks)									

			1 - For State Registrar		partment of Health and ertificate of Death		2001.	5787			
			1. Decedent's Name (First, Middle, Last)	1	, , , , , , , , , , , , , , , , , , , ,	2. Date of Death	Day Vara	ime of Death			
	Physici /Medic		PERCY W. PORTER				Day Year 11	1:18 AM			
	Examin		4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of Dear	h	4c. County of Death				
			Johns Hopkins Bayview	Medical Center	Baltimore		N/A				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Months Days Hours Min		9. Birthplace (S Country)	State or Foreign			
	Director		214-18-8761	83 Yrs.		9-19-19	20	VA			
	pur M		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d los	side City Limits			
	ith the Marylar or 28a-1 show	ņ						ÑYes 2 □ No			
	the N	ect	MD BALTIMORE  10e. Street and Number	EDGE	MERE 10f. Zip Code	100	Citizen of What Country?				
	ath with the Maryla 123a or 28a-1 showns to the contribution	Dir	2306 RUTH AVENUE		21219	109.					
	eath w	Funerai Director		Vas Decedent Ever in U.S. 13		Specify Yes or No-	USA 14. Race - American Indi	ian			
	or Itams	Fun	A	med Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	to Rican, etc.)	Black, White, etc.	icat 1,			
336	ursal	by	3 ☐ Widowed 4 ☐ Divorced	XYes 2 □ No Yes, Give 'ear or Dates: WWII	1 ☐ Yes 2 X No Specify:		Specify: BLACK				
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show ie Mudical Exprignet", ust be trufflad at	Completed	15. Decedent's Education	16a. De	cedent's Usual Occupation	, 16b	. Kind of Business/Industry				
215	hin 7	pie	(Specify only highest grade con Elementary/Secondary (0-12)	rollege (1-4or 5+)	ve kind of work done during most of wa . DO NOT use retired)	rking					
21	giene giene ar tha	OIL	12		ANE OPERATOR	В	ETHLEHEM STEE	EL			
	at Hy l oth	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	Maiden Surname)				
/lai	Ments Ments arked	2	DAVID RICHARDSON		MARY	COPELAND					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after de. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items any injury or other traumatic event, If e Medical Examilination.		19a. Informant's Name/Relationship (Type, F		illing Address (Street and Number or Ri						
	and and a salth		MARY L. PORTER/WIFE		6 RUTH AVENUE BAL	TIMORE, MA	RYLAND 21219				
Baltimore,	of He of He fiten r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	20b. Place of Dis cemetery, c	position (Name of rematory or other place)	Date 20c	. Location - City or Town, Sta	ate			
Ĕ	Pag nent ant: I ury o		* 4 □ Donation 5 □ Other (Specify)	ARBUTUS	MEMORIAL PK. MAY						
alt	permit. Departr Importa any nja		21. Signature of Funeral Service Licensee		22. Name and Address of Facility $ JA $			H., INC.			
8	88 5 8		James 9	morton	1701-31 LAURENS S	T. BALTIM	ORE, MD 2121	. 7			
Ď.	Physician /Medical Examiner		23a. Part Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do not e	enter the mode of dying, such as cardia	or respiratory arrest,	Appro Interv	ximate al Between			
		6 1	Immediate Cause (Final disease or condition	Acute respira	Onset and Death						
7			resulting in death)	)	NORE N.2						
			Description of the land of the	Acute renal	Acute renal failure						
	7 ~	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence or).	Ø <sub>V</sub>						
	cuted	Examiner	fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Coronary arte	ry disease		20 \	years			
Ö,	e exe ian al urial-t	EX	resulting in death) Last	Due to (or as a consequence of):							
3760,	ate be executed hysician and the burial-transit	icai	d								
89	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ned	IF FEMALE:			_					
Вох	th ce tendi	an/h	an/h	an/h	an/h	23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy □Live birth 2 □Fetal death 3	B Ectopic pregnancy		23d. Date of delivery	Vans
	ed fo	Sici	1 Yes 2 No		Other (specify)		Month Day	Year			
P.O.	that the death ned by the atter detached for i	Phy	9 🗆 Onknown								
	res tha igned I be det	þ	Part II. Other significant conditions contribu				co use contribute to the caus				
ord	w requir been si should	ted	Type II Diahetes,	Hyperkusion, Pi	Iminary	1 🗆 Yes	2 ♠No 3 Probably	4 Unknown			
Records,	law las be	Completed by Physician/Med	Fibrosis			24a. Was an autopsy	24b. Were autopsy find prior to completion				
<u> </u>	The ate h	Con				performed 1 ☐ Yes 2 ☐	death? No 1 ☐ Yes 2 🗶 No				
Vital	sian: artific actor,	Be (	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)					
of V	Physician: this certificatal director, p	2	1 ☐ Yes 2 No	1 Ninpatient 2 LEH/Outpati		lome 5 Residence	6 ☐Other (Specify)				
n	ng P	on:	27. Manner of Death 28 1 X Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	njury occurred				
Division	death. ctor: A y the fu	Certification:	2 Accident investigation								
$\geq$	ter direct	ıţ	3 Suicide 6 Could not be 4 Homicide determined 28	28f. Location (Street City or Town, St	and Number or Rural Route ate)	Number,					
	rs al				<del></del>						
	To the Hospital or Attending Physician: The law within 24 hours after death.  To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2   Medicel Exeminer: (	on the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	o, and due to the cause arred at the time, date a	(s) and manner as stated.  and place, and due to the ca-	use(s)			
	the tha mplet	Med	one)	and manner stated.	29c. License number						
	T wit		29b. Signature and title of certifier	Cole	16851		Date signed (Month, Day, Ye  May 16, 200				
	1,		I we	C 009		,	.,, 10/200	1			
	1011		30. Name and address of person who comple	ted cause of death (Item 23a) (Typ	e, Print) Cistern Avenue, Bo	11timore.	MD 21224				
	10										
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 8 2004	22. Registrar's Signature	South						

			1 - For State Registrar	State of M	aryland		artment rtificate					giene Reg. No. 20	04	15788	
	Physici /Medic		Decedent's Name (First, Middle, Last)     John Jacob Pizzo					2. Date o Month May				h Day Year		3. Time of Death 5:00 PM M	
	Examin		1 = 20 11 (21 - 12 12 12 12 13 14 15 1					4b. City, Town, or Location of Death				4c. Count			
			Anne Arundel Medical Center					apo1				Anne			
	Funeral			. Sex 7. Ag 1 ☑ M 2 ☐ F	je (In yrs. la: 84	st birthday) Yrs.	If Under 1 Months	Year Days	If Under :	Min.	8. Date of Birt (Month, Day	v. Year)		place (State or Foreign ntry)	
	Director		169-14-0337 Usual Residence of Decedent	**	-04	113.					June 27	, 1919	Pen	nsylvania	
	yland IOW		10a. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Limits	
	Mar.	to	MD Prince	George's		Вот	wie							1 ☐ Yes 2X☐ No	
	97 28 P 128	Funeral Director	10e. Street and Number				10f. Zip C	Code				10g. Citizen of	What Cour	ntry?	
	238	rai	12106 Rustic H						207				USA		
	er des	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Deceder f Yes, specifi	nt of His y Cubar	spanic Orig n, Mexican	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	14. Ra	ce - Americ ick, White,		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	f 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No 120 66		1 ☐ Yes 2	X No	Specify:			Specii	v:whit	e	
5-0036	within 72 hours after death with the Maryland ene. Ithen "naturel", or items 23a or 28a-f show fe Medical Evantiner maat be rolliked at	edk	15. Decedent's		30-00	16a. Deced	dent's Usual	Occupa	tion			16b. Kind of B	Business/Inc	dustry	
7	nin 72 in "na Wealig	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or	5.1)	(Give life. L	kind of work DO NOT use	done di retired)	uring most	t of workin	g	100.71110		adony	
2	d with giene ar the	mo;	12	3	34)	admi	nistra	tor				milii	tarv		
פ	al Hy al Hy sothe	Be	17. Father's Name (First, Middle, La						18. Mothe	er's Name	(First, Middle.	Maiden Sumai			
Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in a fire 1 stracked other treat real stracked other treatment is event, I've Medical Evantion must be notified at once.	2	John Joseph P									ara Hes			
Ja	2 sho		19a. Informant's Name/Relationship		- 3							r, City or Town		Code)	
	1 and Health em 27 ther t		Judith Hopkins	daugnter	20h Pla	ce of Disno	Wyvil sition (Name	of	1		er Malb ate	oro, MI			
وّ	Pages nent of h int: If ite		1 Burial 2 Cremation 3		cer	metery, cren	natory or oth	er place	)		21.0	20c. Location	- Oity or To	own, state	
	it. Pa intmer intant injury		' 4 ☑ Donation 5 ☐ Other (Spe 21. Signatur of Funeral Pervice Lic	- 0		22	. Name and	Addross	of Facility						
Ba	permit. Departr Imports eny inju		Ronald S	4-1-1-6	ector						655 W.	Baltim	ore S	treet	
			23a. Fart1. Enter the disease, or co	emplications that caused	the death.									Approximate	
	hysician /Medical		shock, or heart failure. List only one cause of each line.  Immediate Cause (Final											Interval Between Onset and Death	
			disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	``								
	Examiner		O C. B. Fat Pat												
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				uence of):								
	physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last												
8760,	cian s		resulting in death, East	Due to (or as	a conseque	ence of):									
687	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	dicai	`	d											
ŏ	eath certific attending p for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	су						23d Da	ite of delive	ary.	
m	death s atter	iciai	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a			Ectopic preg Other <i>(spec</i>							Day Year	
o.	t the c by the ached	hysi	9 Unknown	9□ Unknown											
ת ת	res that the de signed by the a be detached f	by P	Part II. Other significant conditions	ther significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribu			te to the cause of death?	
ğ	w require been sig should b										1 □ Y	es 2 🗆 No	s 2□No 3□Probably 4 Nunknown		
Vital Records,	law re as be 2 sho	Completed									24a. Was a			psy findings available inpletion of cause of	
		Com									perfor	med?	death?	2 No	
Ħ.	ysician: The nis certificate director, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only or	10)			
	Attending Physician: r death. ector: After this certific: by the funeral director.	္င	1 ☐ Yes 2 No	Hospital:			t 3 DOA		4 🗀 1901			ence 6 Oth		)	
5	ding P	ion:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 2	8b. Time of Injury		Work?			8d. Describe h	ow injury occur	red		
200	kttendi death. ctor: A y the fu	icat	2 Accident investigat 3 Suicide 6 Could not	be One Blace of Ini	un. At hom	o farm str	M oot factors s		es 2 🗆 N		Of Location (C	troot and Numb	20101010	l Route Number,	
Division of	l or Attendater death Director: In by the	Certification:	4 Homicide determine	28e. Place of Inj building, et	c. (Specify)	ie, rami, stre	eet, ractory, c	оптсе		-	City or Tow		er or Hura	i Houte Number,	
	spita ours neral filled		29a. Certifier 1 Certifying	Ph <b>ysician</b> : To the best	of my knowl	ledge, death	occurred at	the time	e, date and	d place, ar	nd due to the c	ause(s) and ma	anner as st	ated.	
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	(Check only 2 Medical Ex	aminer: On the basis o and manner st	f examinatio	on and/or inv	estigation, in	n my opi	inion, deat	th occurre	d at the time, d	late and place,	and due to	the cause(s)	
	To the To the comp	Ž	29b. Signature and title of certifier				29c. L	License	number			9d. Date signe			
)			15/				0	4	69	8		5/09	/20	04	
				micron m	leath (Item 2	23a) (Type, I		-	dus	, #	100 B	noduna	15, M,	21401	
:	Sta Registr		31. Date liled (Month, Day, Year)  MAY 1 8 2004	Seren 32. Registr	ar's Signatu	Spa	the				/				

State of Maryland / Department of Health and Mental Hygiene

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							Ce	rtificate	of	Death			Reg. No.	04	10	100
			1. Decedent's Name (Fig.	Decedent's Name (First, Middle, Lest)								2. Date of De	eath Day	Voor	3. Tim	e of Death
	Physici /Medi		Mary Agn	es Pul	lara							May 1		Year 2004	12	:10 PM
N. Section	Examir		4e. Facility Name (If not	institution, giv	e street and nu	ımber)			4	4b. City, To	wn, or Lo	cation of Deat		nty of Death		
1			1207 Dulan	ey Woo	ds Rd	•				Cod	key	sville	Ba	ltimor	е	
T	Funeral		5. Social Security Number	er 6. S	Sex	7. Age (In yrs. I		If Under 1 Months		If Under	24 Hrs. Min.	8. Date of Bi	rth ay, Yeer)	9. Birth	place (Ste	ete or Foreign
	Director		214-05-3642 Usual Residence of Dec	4	1 M 2 K	84	Yrs.					June 6	1919	V N	Ď	
	yland		10a. Stete 10b	. County		10c. City	, Town or Lo	cation						•	0d. Insid	le City Limits
	e Ma	Ş	MD I	Baltimo	ore	Cod	ckeys	/ille							1 🗆 ነ	Yes 2∏ No
	4 th	ē	10e. Street end Number					10f. Zip (	Code				10g. Citizen		ntry?	
	th wi	je L	1207 Dulan	ey Woo	ods Rd	•			21	030			US	Α		
	daa	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U,: orces?	S. 13.	Was Decede	nt of H	ispenic Orl	gin? (Spe	ecify Yes or No Rican, etc.)		lace - Americ		1,
020	s 1 and 2 should be filed within 72 hours after daath with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f show other treumstic event, the Medical Exacting must be indiffed at	by	1 ☐ Never Married 3 ☐ Widowed 4 ☐	_	1 ☐ Yes If Yes, G Year or D	2 <b>∑\</b> No ive		1□Yes 2	_	Specify:		, ,	Spe		hite	
21215-0020	in 72 ho • netur	Completed	(Specify or		ade completed)		16a. Deca (Give life.	dent's Usual kind of work DO NOT use	Occup done o	ation during mosi	t of work	ing	16b. Kind of	Business/In	dustry	
212	within iene. then r	E O	Elementary/Secondary	y (0-12)	College (	1-4or 5+) n/a	Н	airdre	esse	er			Bea	uty		
	Hyg Other	BeC	17. Father's Name (First	, Middle, Last	)					18. Mothe	r's Name	e (First, Middle	, Maiden Sum	eme)		
<u>a</u>	should be filed within and Mental Hygiene. s marked other then " umetic event, the Ma	To B	Epaminund	a Bres	cia					N	1aria	Gargu	alio			
Maryland	should by many summer		19a. Informant's Name/	Relationship (	Type, Print)		19b. Maili	ng Address (	Street	end Numbe	or Rura	al Route Numb	er, City or Tov	vn, Stete, Zip	Code)	
	and 2 alth a		Janis M. P	lantho	lt/daug	hter	1207	Dular	ney	Wood	ls R	d., Co	ckeysv	ille, M	1D 2	.1030
Baltimore,	permit. Pages 1 and 2 sho. Department of Health and M important: if Item 27 is mar eny injury or other treumet once.		20a. Method of Dispositi		Domewal from	00	ace of Dispo	sition (Neme matory or oth	of er plea	<b>&gt;e</b> )	I	Date	20c. Locatio	n - City or To	own, State	•
Ē	Pag ment: if		4 Donation 5				laney	Valle	M	ausol	eum	5/20/0	4 Tim	onium	, MI	)
alt	permit. Departrimports eny inj		21. Signature of Funera	Service Lice	nsee		22	2. Name and	Addres	ss of Facilit	у На	ome of	Dulane	v Val	lev	Inc
ш	20529	i i	Michae	17.4	agle							Timo:				
10			23a. Part1. Enter the di shock, or heart feil	sease, or com ure. List only	plicetions that	caused the death									Approxi	mate Between
1	Physician													1	Onset a	ind Death
1	/Medical Examiner		Immediate Cause (Final disease or condition		CAR	-DIOMY	OPAT	44								
	_xammer	L.	resulting in death)				as a consec									
_	ed isit	를			b. ATH	EROSC	LERO	sis								
1	certificate be axecuted ding physician and se as the burial-transit	Examine	Sequentially list condition if any, leading to immed cause. Enter Underlying Ceuse (Disease or injury)	ons, late		Due to (or	as a consec	quence of):						į		
68760,	siciar siciar buni	al	Cause. Enter Underlying Ceuse (Disease or injury that initieted events	<i>*</i>	C	Dura to Jos										
687	ficate g phy is the	/Medical	resulting in death) Last	1		Due to (or	as e conseq	uence or):								
ŏ				•	d								- \			
Ω.	death e atte	cla	Part II. Other significent	conditions	ontributing to d	eeth but not resu	lting in the u	nderlying car	ıse aiv	en in Part I.		23b. Dld	tobacco use	contribute to	the cau	se of death?
P.0	t tha by th tache	Physiciar	2-11		_							10	Yes 2000	3 □ Pro	bably 4	4 ☐ Unknown
	s tha gned se de	by F	ICENAL	FAI	LURE											
of Vital Records,	The law requires that tha death ate has been signed by the atten page 2 should be detached for u	be	DILBUTE	- (								24a. Was	en autopsy ormed?	av	eilable pri	
ပ္မ	8 5 5	ple	DIADETE									,		co of	mpletion death?	of cause
æ	The I	Completed										10	Yas 22Mo	10	Yes 1	2 No
/ita	ifclan: The certificate rector, pag	Be	25. Was case referred to examiner?	medical						26. Plece	of Death	Check only	one)		17.7	
× ×	Physician: rthis certificantal director,	ို	1 ☐ Yes 2)5.No		Hospital: 1	Inpatient 2 □ f	ER/Outpatier			4 🗆 Nu	rsing Ho	me 5 Resi	denca 6 □C	Other (Specif	y)	
2	ng P	ë ë	27. Manner of Death 1 X Natural 5 [	☐ Pending		of Injury oth, Dey Year)	28b. Time of Injury		. Injun Worl		_	28d. Describe	how injury occ	curred		
Sio	Attending at death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicide 6	investigation  Could not b				М		Yes 2 □ I		oof Landing	(Ct		- ( (1)	
Division	or Attendi aftar daath. Director: A i in by the fu	Certification:	4 ☐ Homicide	determined	286. Place	e of Injury - At ho ing, etc. <i>(Specify</i>	me, farm, str )	eet, fectory,	office			28f. Location ( City or To		mber or Hura	ii Houte N	iumber,
	pital ours a orai [		29a. Certifier	Cartifulno Ph	velcles: To the	best of my know	dedae death	occurred at	the tim	no data an	d plage	and due to the	aguag(a) and	mannar a	totod	
	To the Hospital or Attending Physicien: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical			niner: On the b	asis of examinati ner steted.										se(s)
	othin othin	Me	29b. Signature and title	of certifier				29c.	License	e number			29d. Date sig	ned (Month,	Day, Yee	r)
	, , , , , ,		Sta 0	en 1	Plan	thent	H	1 0	0	2023	358	0	Man	7 2	004	1
	1		30. Neme and address of	of person who	completed caus	se of death (Item	23a) (Type.	Print)		- 200			S	1		
			Stephen J	Plant					ıs A	۱ve.	#300	, Balto	o., MD	21229	1	
	Sta	ite	31. Date filed (Month, Da	ay, Year)	32. F	Registrar's Signat										
	Registr	ar		AY 1 8	211114	Thomas of a	18	Prast.	10	*						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year DELANEY RENFRO /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death NIA GBMC GILCHRIST BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□ F 413.54.566 Yrs Director TN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic avant, the Medical Examinatings to notified at HOWARD 1 ☐ Yes 2 X No MO ELKRIDGE Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6769 OLD WATERLOO RD 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SELECTOR YRS PRODUCE 12-TH GRADE FOOD INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLAUDE RENTRO FRANCIS CORONETI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other tratonce. KATHRINE 6604 DEEP RUN PKWY. ELKRIDGE ace of Disposition (Name of Date 20c. Location - C KENFRO MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 05-21-04 OWINGS MILLS, MO 21. Signature of Funeral Service Licens 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATE PIKE, BALTO MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) melmomA **Physician** metastatic Rak /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): attending physician by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 2 4 Nursing Home 5 Residence 6 X Other (Specify) ₩ 0 C 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25205 MAY 14, 200 % 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print)

W. A. R. (Ley GBMC 6701 N. Char N. Charles St. Balto md 2 (20)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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ORIGINAL

32. Registrar's Signature

			1 - For State Registrar	State of Maryland	/ Departme	nt of Health and te of Death	•	ne 2001.	15791
	Physici		1. Decedent's Name (First, Middle, Last)	ORERTS			2. Date of Death Month	Day Year	3. Time of Death
}	/Medic Examin		Social Security Number	OSPITAL	st birthday) If Und	y, Town, or Location of Dea ATT Y R er 1 Year If Under 24 Hrs s Days Hours Min	8. Date of Birth (Month, Day, Ye	4c. County of Death	
	Director  Maryland  Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City,	Town or Location ALTIM	pre	12 19 19	28	10d. Inside City Limits 1 ⊠Yes 2 □ No
	th with the 23a or 28	al Director	10e. Street and Number ID2T N. CATHEDR	AL STREET A	HPT. 100	2/20/	10g.	Citizen of What Cou	· .
036	within 72 hours after death with the Maryland ane. than "naturel", or items 23e or 28e-1 show the Medical Exercited Trust for putilled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 254 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	, etc.
21215-0036	T 5 4 5	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th grade	cation o completed)  College (1-4or 5+)		ual Occupation rork done during most of wo use retired) SEWIFC	rking 16b.	RIVAT	•
Maryland	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name First, Middle, Last) DUBOIS M. B			EVA	me (First, Middle, Maid COLEM)	4N	
	t and 2 should dealth and Mer om 27 is marke ther traumatic		19a. Informant's Name/Relationship (Typ. WILLIAM ROBE  20a. Method of Disposition	RTS, III	6910 D	ss (Street and Number or Ri	BALTIM:	ore MI	0 21207
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Maurial 2 □ Cremation 3 □ Re     4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	ARI		10MORIAL 05/	20/04 B	Location - City or T	,MD
Ba	permi Depa impo eny ii		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	1	Do not enler the mo	and Address of Facility  SHO C. GREE  BAUTIMORE NA  added of dying, such as cardia	ENC FUNC TIONAL PIKE C or respiratory arrest,	BALTIMI	Approximate
	Pnysician /Medical Examiner		snock, or neart failure. List only on Immediate Cause (Final disease or condition resulting in death)		y ART	vey Distant			Interval Between Onset and Death VRAS
3760,	ite be executed fysicien and burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause that hooding Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer					
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown	Sc. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic			23d. Date of deliver Month	ery Day Year
rds, P	The law requires that the te has been signed by thoage 2 should be detache	ed by Pl	Part II. Other significant conditions conf			cause given in Part I.		o use contribute to t	he cause of death?
Vital Records,		Completed by					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
of	ding Phys n. After this funeral di	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2  He  27. Manner of Death  1  Accident   Pending investigation	-	VOutpatient 3 C 3b. Time of Injury	04	inth (Check only one)  ome 5 Residence  28d. Describe how in		(y)
Division	afte Dir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, facto	ry, office	28f. Location (Street: City or Town, Sta	and Number or Rura te)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physical Control one)	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occurre a and/or investigatio	d at the time, date and place n, in my opinion, death occu	, and due to the cause rred at the time, date a	s) and manner as s nd place, and due to	tated. o the cause(s)
2	To T Com	M	29b. Signature and title of certifier	ista, Ms		C. License number		ate signed (Month,	Day, Year) 2004
	D	0	30. Name and address for roon who con SCP1 (SN-31. Date filed (Month, Day, Year)	^ -	PAUL	PULLE B.	ACTIMORE	S OM,	(201
	Sta Registr		MAY 1 8 2004	popura	B 500	Who!			

		•	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of			giene 99. No. 200	+ 15792
) * * * * * * * * * * * * * * * * * * *	Physici /Medic	al	Dowthy Ric     A. Fecility Name (# not institution, give	laley		4b. City, Town, o	or Location of Dea	2. Date of Dea Month May	Day Year  Day Year  Ac. County of Dec	1.33 FM
	Funeral Director		5. Social Security Number 6. S 214–18–9321	June Medica  ox 7. Age  Medica  7. Age  8	(In yrs. last birthday)	Baltim If Under 1 Year Months Days			NA (, <sub>Year)</sub> 9. Bi	rthplece (State or Foreign ountry) Md •
e Maryland	Sa-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Md . NA		10c. City, Town or Lo	re				10d. Inside City Limits 1 X Yes 2 No
1273-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f show spinjury or other traumatic event, the Medical Exercities must be notified at ance.	by Funerai	10e. Street and Number  815 N. Dukeland  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:	16a. Dece	1 ☐ Yes 2X No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	USA  14. Race - Am Black, Wh  Specify: B]	encan Indian, ite, etc. .ack
<b>2</b>	Hygiene. other then "nu ent, the Media	e Completed	(Specify only highest gri Elementary/Secondary (0·12) 10th grade 17. Father's Name (First, Middle, Last	College (1-4or 5+	·) life.	kind of work done DO NOT use retire	d)	ime (First, Middle,		ople Homes
	lealth and Mental m 27 is marked o her traumatic eve	To Be	Unkn 19a. Informant's Name/Relationship ( Phillip Ridgle)	•			and Number or F	atrice Dural Route Numbel , Baltimo	Barre r, City or Town, State, re, Md. 2	
Pages 1	Department of Hea Important: If Item: eny injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	20b. Place of Dispo cemetery, cres Garrison	osition (Name of matory or other pla	<sub>сө)</sub> Vet. 5-	Date 18-04	20c. Location - City o	lls, Md.
Balt Permit.	Depar Impor		21. Signature of Juneral Service Lice  23a. Pert1. Enter the disease, or conshock, or heart failure. List only	plications that caused	the death. Do not ent	March F. ter the mode of dying	H. East	1101 E.	imore, Md North Ave	Approximate Interval Between
/1	ysician Medical aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	iddle Cereb, consequence of): ibrillation	ral Artery	Ischemic	Infarct		Six days
Box 68/60, death certificate be executed	physician and the burial-transit	licai Examiner	S puentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):					
	ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 9 ☐ Unknown	Petal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of do Month	elivery Day Year
<b>J</b> #	been signed by the a should be detached f	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
r g	is certificate has be director, page 2 sh	e Completed	25. Was case referred to medical				00 Blace of D		sy prior to med? death? 2.24 No 1 □ Ye	
on of Vital	After th uneral	ToB	examiner? 1 Yes 27 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 X Inpatier 28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Inju	ner: 4 🗆 Nursing		ence 6 Other (Sp ow injury occurred	ecify)
Division tel or Attending	fter deat Sirector: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not to determined	00 Place of Injur	ry - At home, farm, st (Specify)		,103 2 110	28f. Location (S City or Town	itreet and Number or F n, State)	Rural Route Number,
The Hospitel	within 24 hours after of the Funeral Direct completely filled in by	Medical		hysician: To the best o miner: On the basis of and manner stat	examination and/or in		opinion, death occ	curred at the time, o		e to the cause(s)
<u>۽</u>	05 T Wil		30. Name and address of person who	MD completed cause of de	eath (Item 23a) (Type,	P16	589		May , 12 .	2004
	Sta Regist	ate rar		2 South Gra 32. Registra			timore,	Marylund	1 2120	(

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Certification: To 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical [2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

within 24 hours a To the Funaral I

To the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NHC, BALT MO

MAY 12, 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of Mi	arytari	Cei	tificate of	Death	and Mental r	Reg.		UЦ	15794
	Physici	an	Decedent's Name (First, Middle, Last			Dath			2. Date of Month		<sup>Day</sup> 2004	Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give	Michael J	ames	Rotn	4b. City, Town, o	or Location	of Death	11,	4c. County (	of Death	2334 P M
	Examir	ier	5234 4th Street	stroot 210 namoory			Brook		or bourn		Anne		del
	Funeral Director		5. Social Security Number 6. Se 220 56 1448	x 7.Ag SIM 2□F	ө (In yrs. I. 50	ast birthday) Yrs.	If Under 1 Year Months Days	**	24 Hrs. 8. Date of (Month, July	Birth Day, Ye 1, 1		9. Birthpl Count	ace (State or Foreign ry) Yland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					10	Od. Inside City Limits
	Maryle f sho	ō	Maryland Anne Ar	undel	1	cookly							1 ☐ Yes 2X No
	r 28a-	rect	10e. Street and Number				10f. Zip Code			10g.	Citizen of W	hat Count	ry?
	th with	al D	5234 - 4th Stree	et			212	25			U.S.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumetic event, tre Modical Examinal templified at once.	by Funeral Director	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:		1	Was Decedent of H f Yes, specify Cub. I ☐ Yes 2X No		igin? (Specify Yes or n, Puerto Rican, etc.)	No-	Black	America k, White, e Whi	itc.
5-0	72 ho natur	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced	lent's Usual Occup	ation durina mos	st of workina	16b	. Kind of Bus	siness/Ind	ustry
2121	filed within Hygiene. othar than "ant, ine Max	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work done DO NOT use retired hinist				Locke		lator
Maryland 21215-0036	should be fill the Mental His markad oth umatic evan	To Be		Henry Rot	h				er's Name (First, Mid Isabell N	/urpl	ny		
Mar	d 2 sh th and th and traum		19a. Informant's Name/Relationship (7)  Donna Roth / Wif				g Address ( <i>Str</i> eet - 4th St		er or Rural Route Nu Baltin				
	s 1 an f Heal itam 2 othar		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Name of natory or other place	ca)	Date	-	. Location - (		
<u>E</u>	Page nent o ant: If ary or		1 XBurial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)						5/17/2004	G.	len Bu	ırnie	, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 I any injury or other tra		21. Signature o Funeral Service Licens	rimish	usk		Name and Addre		y Gonce Fi Ighway B	ner alti	al Ser more,	vice Mary	, P.A. land 21225
SHEET STATES	Fnysician /Medical Examiner			ications that caused ne cause on each lie a.  Due to (or as	a consequ	ence of):	er the mode of dyir	ng, such as	cardiac or respirator	y arrest,			Approximate interval Between Onset and Death
68760,	tificate be executed og physician and as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as									
P.O. Box 6	death cer e attendir sd for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal	death 3	Ectopic pregnancy Other (specify)	у		-	23d. Date Mont	of deliver	y Day Year
	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other significant conditions co	ntributing to death b	ut not resu	Iting in the ur	nderlying cause giv	ven in Part I		id tobaco □ Yes	100		e cause of death?
al Records,	n: The law requicate has been r, page 2 should	Completed							24a. W au pe 1/2/Ye	itopsy ortormed	? pr	ior to comeath?	sy findings available pletion of cause of
of Vital	Physician: r this certificanal director,	o Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	Hospital: 1 ☐ Inpatie	2 🗆	ER/Outpatien	Oth	or	of Death (Check on		. 670.0	10 11	7 + ingone
Division of	ding h. Afte fune	Certification; To	27. Manner of Death  1 Natural 5 Pending investigation  3 Vuicide 4 Homicide 6 Could not be determined	28a. Date of Inju	ry y Year) Y ury - At hor	28b. Time of Injury me, farm, stre	28c. Injur Wor		No Su	pe now in	and Number	d uge	At scene
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ⅓ Medical Exami	sician: To the best	of my know	vledge, death	occurred at the tir	me, date ar	nd place, and due to the time	he cause	(s) and man	ner as sta	ton, MD
	tha H hin 24 tha F nplete	Medical	<b>○</b> (E)	and manner sta	ited.	on anaron inv			occurred at the th				
•	2 mm 2 mg	~	29b. Signature and title of certifier	Sur			29c. Licens	M.E.			Date signed ay 12,		
	1		30. Name and address of person who co	ompleted cause of d		23a) (Type, I 11	<sup>orint)</sup> L Penn St	reet	, Balt <u>i</u> mor	e, M	arylar	nd 21	201

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) WAY 1 8 2004

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32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last Month 5:05 AM **Physician** fleuth 200 Y Knine /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner maritan timo Ostorta N/A a If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 💢 F 72 213-28-4357 Director January 13,1982 Maryland Usuel Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show itsm 27 is marked other than "natural", or itsms 23a or 28a-f show other trsumatic event, the Medical Examinar must be notified at 1 Yes 2 No N/A Baltimore City Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4607 Furley Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filled within 7. In and Mental Hygiene. 7 is marked other then "n. College (1-4or 5+) Elementary/Secondary (0-12) 8th Home maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Spresser Thelma Willard Elmer permit. Pages 1 and 2 sho Depertment of Heelth and M. Important: If Itsm 27 is many injury or other. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21206 4607 Furley Avenue Charles J. Rhine - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hilltop Service 5/20/04 Towson, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Baltimore, Maryland 2 Inc. 5305 Harford Rd Maryland 21214 lan Ruck. eonard J. 23a. Pert1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) spirat 0 Pnysician /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physician end for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of deeth 5 Other (specify) been signed by the should be deteched 9□ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Obstructive Pulmonary 4 Unknown 1 Yes 2 No 3 Probably Completed Coronary ARTERY 24a. Was an autopsy performed? 1 ☐ Yes 2 LaNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this cer ificate s after deen... rai Director. After this cerm... Hospital or Attending Physician: Ble 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide 24 hours 1 🎾 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie within 24 hou To the Fune completely fi Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of Curtifier 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601

DMITRIY PINELS

Raltimore Lock Roven 21230 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 8 2004

			For	State of Ma	arylan		artment of F		Mental Hy	giene	0.01	l from the same
			State Registrar	1		Ce	rtificate of	Death	2. Date of De	Reg. No.	U U 4	me of Death
	Physicia	100	Decedent's Name (First, Middle,     Robert Rob	A STIN					Month	15 2	004 4	15 PM
	/Medic Examin		4a. Facility Name (It not institution,	give street and number)	1 .	201 4	4b. City, Town, o	r Location of Dea	th	4c. County	y of Death	*
			University of Mc	orgiand Me	Clica	licent	er	Baltin	OR		VA	
	Funeral		5. Social Security Number 219 28 0036	5. Sex 7. Ag 1 M 212 F		71 Yrs.	Months Days	Hours Min		h <i>y, Year)</i> 7 1932	9. Birthplace (S Country) MARYLAN	State or Foreign
la.	Director		Usual Residence of Decedent			, <del>-</del>			001411	17 1552		
	be filed within 72 hours after death with the Maryland tal Hygiene.  dother than "natural", or Itams 23a or 28a-f show event, the Medical Examinant must be notified at	ž	MD. 10b. County			ty, Town or Li TIMORE						ide City Limits
	28a-f	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?	
	h with 23a or	al Di	4208 GRANADA AV	Æ			21215			U.S.A		
	r deal	uner	11. Marital Status	12. Was Decedent Armed Forces?	•	.S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ce - American Indi ick, White, etc.	ian,
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 31 ☑ Widowed 4 ☐ Divorced	lf Yes 2√1 If Yes, Give Year or Dates:	No		1 ☐ Yes 💥 ☐ No	Specify:		Specia	bLACK	
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d 2	filed v Hygie other t		12TH 17. Father's Name (First, Middle, L	N/A ast)		HOUSE	WILE	18. Mother's Na	ame (First, Middle,		тө)	
lan		To Be	ALTON ROBINSON					FANNIE (	CLARK			
Maryland 21215-0036	2 shc and is ma		19a. Informant's Name/Relationsh BRENDA HARRIS	ip (Type, Print)			ing Address (Street GRANADA A					
	1 and 1 am 2 am 2 ther		20a. Method of Disposition		20b. I	Place of Disp	osition (Name of	i	Date Date		- City or Town, St	ate
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ☑Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		)	-	matory or other pla	1	2004	BATTTMC	DRE, MD.	
altii	permit. F Departm Importar any inju		21 Signature of Funeral Service L		, 211	2	2. Name and Addre	ess of Facility (	CALVIN B.	SCRUGO	SS FUNERA	
8	8888		Olmader	rel. De	rug		412 E. PI					L3 eximate
			23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each I	orthe prea	TM. Do not en	ter the mode of dyl	ng, such as cardi	ac or respiratory a	rrest,	Interv	al Between t and Death
Y	Physician /Medical		disease or condition resulting in death)	a. SCOS Due to (br as	a consec	quence of):						
	Examiner		Sequentially list conditions	b								
	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	quence of):						
	le be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consec	quence of):						
760,	ate be executed sysicien and he burial-transit	cal		d								
99	The law requires that the death certificate are has been signed by the attending phy page 2 should be detached for use as the	Med	IF FEMALE:	000 15								
Вох	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 poinths?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fet	al death 3	□Ectopic pregnanc	у			ate of delivery onth Day	Year
P.O.	that the de ed by the a detached f	hysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unknown							_	
	uires that signed b	by P	Part II. Other significant condition	ns contributing to death	but not re	sulting in the	underlying cause gr	ven in Part I.			ntribute to the caus	
ord	w requir been si should	eted								Yes 2 No		
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Vital		0	25. Was case referred to medical					26. Place of D	eath (Check only		1 ☐ Yes 2 ☐ N	10
f Vi	Physician: r this certific ral director.	ToB	examiner?	Hospital:	ient 2	] ER/Outpatie	ent 3 DOA	hac	Home 5 ☐ Res		ther (Specify)	
n of	ing Pt Viter th uneral		27. Manner of Death 1 Natural 5 ☐ Pendin		ury ay Year)	28b. Time Injury	Wo	ryat ork? ]Yes 2 ∐No	28d. Describe	how injury occu	irred	
Division	ttendi death. ctor: A y the fu	licat	2 Accident investig	ot be 28e. Place of Ir			M 1 [				ber or Rural Rout	e Number,
ρŃ	al or A s after i Dire	Certification;	4 Homicide	building, e	itc. (Spec	ify)			City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the bes Examiner: On the basis	of examin	nowledge, dea	th occurred at the t	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place	nanner as stated.	ause(s)
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner s	tated.		29c. Licen	se number		29d. Date sign	ed (Month, Day, Y	'ear)
	, ¥ , 8		▶ YMW	M CRIM	0		MIH	452		May	15,200	24
	9		30. Name and address of person	who completed cause of	death (Ite	om 23a) (Type	p, Print)	ing sar	eet, B	141	CO M	ON IAC NO
			1 POLO SER PUCCO	32. Regis	LL trare sin	- Sou	in will	110 011	COI D	, CHITTIO	10) 100	91001
	St Regist	ate	31. Date filed (Month, Day, Year) MAY 1 8 200		uais sign	4	books					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear **Physician** Inez Samet 1:45 AM MAY 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMONE CITY HOSPITAL OF BAITMONE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Oct 23, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary Land 1 □ M 2 🛛 F 213-20-9557 78 Yrs Director Usual Residence of Decedent 10c. City, Town or Location ahow 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f abov treumatic event, the Medical Event nor must be notified at MD 1 Yes 2 No Baltimore Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 1500 Bedford Avenue #205 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 2 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " College (1-4or 5+) Elementary/Secondary (0-12) data processing financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) i and Mental I Louis Englander Rose Sklar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ent: if item 27 is Sandy Wilkerson/daughter Castle Drive Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Depertment of Importent: if any injury or once. `4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street minny 23a. P.n.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPT Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STEWOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown CRITICAL AONTIC CAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To s after death.
I Director: After this of in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) determined 4 Homicide

Box 68760, Records, P.O. of Vital Division Hospitei To the

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2

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a

To the Funerel C

completely filled

filled

Medicai

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 1 8 2004

DAVID

1 D.O .

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

(0221

32. Registrar's Signature

Terifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

HOSPITAL

29c. License number

RES-000

OF BATTIMONK

29d. Date signed (Month, Day, Year)

2004

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		-	For Amend Item #20e- State Registrar	State of Manylany	A Penartme Certifica	nt of Heal te of Dea	th and Me		giene Reg. No.(	Z [ ] ] ] [	15798
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic	_	Joh	n F. Sonders				Month OS	16 Day	<u> </u>	7:00AM
)	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City	Town, or Loca	ation of Death		4c.	County of Death	
			2854 W. Garrisi	m Avenue		Battin	nove			NA	
	Funeral		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. la	st birthday) If Undo Months		ours Min.	8. Date of Birt (Month, Da	th y, Year)	9 Birth Cou	place (State or Foreign
	Director	1	Usual Residence of Decedent	/5	113.			2/6	119	3/	
	/land	-	10a. State 10b. County	10c. City	, Town or Location						10d. Inside City Limits
	Many fled	ţ	MD NA		Pr	Himor	e				1 Yes 2 No
	h the	Director	10e. Street and Number	A	10f. Z	ip Code			10g. Citiz	zen of What Cou	ntry?
	death with the Maryland ims 23e or 28e-f show	aiD	2854 W. Garris	on Avenue		213	715			USA	
	r dea	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	S. 13. Was Dec If Yes, sp	edent of Hispan ecify Cuban, Me	ic Origin? (Spe exican, Puerto F	cify Yes or No Rican, etc.)	- 1	14. Race - Ameri Black, White	
36	or II	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes	10	ecify:		1	Specify: Qi	NOV
Ö	72 hours after natural', or Ite	d b	3 Widowed 4 Divorced	Year or Dates:	16a. Decedent's Us	ual Occupation			16b Kir	nd of Business/li	ACK
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212	f within lene. r than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Masi	er Au	mber		1	Jumbi	na
	e filed I Hyg othar	Be C	17. Father's Name (First, Middle, Last)			18.1	Mother's Name	(First, Middle,	Maiden	Sumame)	
<u>lar</u>	Aental Aental rkad c	To B	10m San	ders			Virgi	nia i	Ferc	PISM	•
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hyglens. If item 27 is marked other than "natural; or Items 23e or 28e-f show or other treumatic event, the Medical Everther must be rediffed at		19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Addres	ss (Street and N	lumber or Rura.	Route Number	er, City o	Town, State, Zi	o Code)
	of Health of Health litem 27 i		Kegena Sanders 1	Daughter)	P.O. Box	104 (	ockeus	sville.	M	) 210	30
Baltimore,	of He		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ R	emoval from State 20b. Pl	ace of Disposition (N. Imptery, crematory or edar, Hill Ce	ame of other place)	[E-92 A	ate +		cation - City or T	own, State
Ë	artment ortant: ortant: injury c	. 3	* 4 □ Donation 5 □ Other (Specify)		COOSTH C	nevery	3374	-04		imore, MD	
Salt	permit. Pages 'Department of Himportant: If its any injury or ot once.		21. Signature of Funeral Service License	98	22. Name	and Address of	Facility Jau	ighn C	Gre	enefun	eral Service
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8760	cate be executed physician and the burial-transit	dicai									
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Вох	eath certific attending p	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal		pregnancy			2	23d. Date of deliv	,
	e dea he at led fo	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	eath 5 Other	specify)				Month	Day Year
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Division of	Phys r this rral di	1: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ I	28b. Time of	28c. Injury at Work?	Nursing Hon	18d. Describe I	dence (	Other (Spec	<i>'y')</i>
on	th. th: After funer	tlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes	2 No				
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Ö	al or s afte of in b	Certification;	4 Homicide	building, etc. (Specify	"			City or To	wn, State,	/	
	To the Hospital or Attandin within 24 hours after death. To the Funaral Director: Att completely filled in by the fun	salc	29a. Certifier Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	wledge, death occurre	d at the time, do	ate and place, a	and due to the	cause(s)	and manner as	stated.
	the H in 24 the Fi iplete	Medical	one)	and manner stated.				, at the time,			
	with To 1	Σ	29b. Signature and title of certifier	0 -	2	9c. License nun				e signed (Month	Day, Year)
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	N		30. Name and address of person who co			4	1000				
	61		31. Date filed (Month, Day, Year)	32. Rægistrar's Signal			210:17				
	St. Regist	ate	MANU 1 0 20	37	K Local	1					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month Year 12:23 PM **Physician** BARBARA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAL 41 If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6 Sax **Funeral** Min. Year Days Months Hours 1□ M 2/ F Usual Residence of Decedent ARCH 8 100x1 Director 10c. City. Town or Location 10d, Inside City Limits death with the Maryland 10a. State 10b. County show ortant; if itam 27 is markad othar than "natural", or Itams 23a or 28a-f shov injury or othar traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No HARFOR Directo DARTHU 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ·A BLEWOOD 21014 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced DHILL Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "nt any inury or othar traumatic event, the Media once. College (1-4or 5+) Elementary/Secondary (0-12) AI ioyrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ARRIGO LORNEW ပ 15555 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 953 BE 20b. Place of Disposition (Name of cemetery, crematory or other place) JAY 20 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State FORSST 1ARYLAND 4004 \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signality of Funery Service Licer 21234 221901 BRYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) holangiocarcinons Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician; The law requires that the death cartilicate be executed burial-tran Due to (or as a consequence of): Box 68760, by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No P.O. the 9☐ Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ed bluods 1 Tyes 2)X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy page 2 certificate has 25 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6. Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Atter 5 Pending 1 Natural 1 Tyes 2 No investigation death. 2 Accident Diractor: Could not be 3 🗀 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

ST

105 Registrar's Signature 29c. License number

4085L

29d. Date signed (Month, Day, Year)

md

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tor Amend Item 26 per atate 31/08/18/04/19 partment of Health and Mental Hygiene 1- State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Leocation of Death **Examiner** tora 8. Date of Birth (Month, Day, Year) 7-3-1928 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 850 Yrs. Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** MF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA 21050 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No ŏ Maryland 21215-0036 Specify: Completed by fYes, Give Year or Dates: Specify: 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Elementary/Şecondary (0-12) College (1-4or 5+) 13. pervisor 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 ) (ra 19a. Informant's Name/Rela onship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 KOCK Date torest Hill MD 21050 Baltimore, 20b. Place of Disposition (Name of cometer), crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 PA 4 Donation 5 Other (Specify) 3 □Removal from State ⁴ 4 □ Donation CHAPPIT. 21. Signature of Funeral Service Licersee 22. Name and Address of Facility FOREST HILL MD ZIOSO EVANS FUNGRALCHAPEL-BEL AIR, 3NEWPURT DR 23a. Part 1. Enter the disease or complications hat caused the dishock, or heart failure. List only one of use on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1048 /Medical Due (or as a consequence of) **Examiner** 30 years ter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying tasses (Lister Underlying that initiated events resulting in death) Last Due to (or consequence of). Due to (or as a consequence of): Box 68760 attending physician Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 2 **N**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 3 Aresidence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 2 ER/Outpatient 3 X DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After Hospital or Attending 5 Pending investigation 1 Natural 1 Tes 2 No Director: , 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after n 24 hour. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. To the F the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lyun W. Welle D15827 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MOMPH

\$2. Registrar's Signature

M. Wells

31. Date filed (Month, Day, Year)
MAY 1 8 2004

560 West MacPhil

State of Maryland / Department of Health and Mental Hygiene 2004 For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 0657AM 2004 Latta Smith Gloria MA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) BALTIMORE UNIVERSITU If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M XXF MD 78 Director 214-20-3203 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1X Yes 2 No Director NA Baltimore MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21217 U.S.A. 2601 Madison Ave Apt 101 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2K No 1 Never Married XXMarried 21215-0036 1 ☐ Yes 2/ONNo Specify. If Yes, Give Year or Dates: ۵ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electronics Tech. Western House 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland nd Mental Myrtle Dunton Thomas L. Ball 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Saunders J. Smith-Husband 2601 Madison Ave Apt 101, Baltimore Md 21217 Pages 1 and Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) / King Memorial Park 5/19/04 Randallstown, Md 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician oronary resulting in death) /Medical Due to (or as a consequence of): Examiner Drobetes Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-transi perfension Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Tripatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D34974 · cpretite ins May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 601, South Charles Street, Baltimore, MD21230 CHARU MEHTA, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State ooks MAY 1 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

HHICH KNOWY OS JOSEPH HENRY JULLINE

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 1045 2004 Joseph Henry Sullivan May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balhmore City Vinai Hospital of Baltimore N/A | Dall | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O8-19-1921 6. Sex Birthplace (State or Foreign Country)
 SC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral XXM** 2□ F Months 218-18-6644 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23e or 28a-1 show other treumatic event, the Medical Example, and 1 X Yes 2 □ No Director MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901 Groveland Ave. Apt.A1 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes. Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 € No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Kraft's General Elementary/Secondary (0-12) 8 years College (1-4or 5+) Lineman Machine Operator Food Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be far and Mental F William T. Sullivan Rhoda Tillington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Sullivan/ Wife 3901 Groveland Ave. Apt., A1 Balto., MD 21215 t of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 5-21-04 Owings Mills, MD Garrison Forest 21. Signature of Fune al Service Ligense 22. Name and Address of Facility Howell Funeral Home 4600 Liberty Heights Ave. Balto., Md 21207 Faith. En er the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Sepsis
Due to (or as a consequence of) 3 days disease or condition resulting in death) /Medical Examiner CVA 9 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Unknown Keral failure, Multiple Mylioma 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 Rio 1 hpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 May 14, 2004

Registrar

State

hispital of Bellmore

30. Name and ad rest of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SON ERIC S	5CO	TT 1 = State Unpend Item #23a,27, Registrar	te of Maryland 28a f per me	d / Depa 6831_5/ Cer	utment of H 27/04 tas tificate of	lealth and I Death	Mental Hy	giene Reg. No. 2001	1580
		Decedent's Name (First, Middle, Last)					2. Date of De	aath	3. Time of Death
Physic /Med		Jason Eric Scott					MAY	15, Day 2004 Year	0700 A N
Exam		4a. Facility Name (If not institution, give street a	and number)		4b. City, Town, or	Location of Death	)	4c. County of Deal	th
C		26 Prospect Avenue			CATONS			BALTIMOR	E
Funera Director		5. Social Security Number 6. Sex 125M 2	7. Age (In yrs. I.	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct 12,	ay, Year) 9. Bin Co 1968 Mary	hplace (State or Foreig ountry) 1and
2 >		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
Mary 1 sho	ō	Maryland Baltimore	C	atonsv	ille				1 □ Yes 2 HN
ith the Marylar or 28a-f show	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untov?
h with	D E	26 Prospect Avenue			212	28		U.S.A.	
deat	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No	)- 14. Race - Ame	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Medical Examirer must be notified at	b	1 X Never Married 2 ☐ Married 1 ☐	Yes 2⊠No es, Give ar or Dates:		35	Specify:	rican, etc.)	0	e, etc. iite
21215-0036 ad within 72 hours att giene. er than "natural", or than "wed call exern	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired	turing most of won	king	16b. Kind of Business/	Industry
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Vial	10	Unknown				Janice	Edith	Segraves	
Maryland d 2 should be file th and Mental Hy 7 is marked oth	1	19a. Informant's Name/Relationship (Type, Prin		19b. Mailing	Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town, State, 2	lip Code)
and and lealth m 27	1	Janice Scott (Mothe					-	e, MD 21228	
Baltimore, sernit. Pages 1 ar Department of Heal mportant: If Item my injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ Remova	I from State	metery, crem	ition (Name of atory or other place	9)	Date	20c. Location - City or	
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Baltimore, Misperial Pages 1 and 2 Department of Health a Important: If tiem 27 is eny injury or other tra		21. Signature Huneral Service Licental	lasto	22. W:	Name and Addres itzke Fur 530 Edmor	s of Facility neral Hom ndson Ave	e of Ca	tonsville, onsville, M	Inc. D 21228
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On O ding Ph h. After th funeral	tion		(Month, Day Year)	Injury	28c. Injury Work	es 2. <b>X</b> No	Unknown	ow injury occurred	
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Hospite 4 hours Funera ely fille	edical C	29a. Certifier  (Check only  1 Certifying Physician: 2 Medical Examiner: On	To the best of my know	ledge, death on and/or inve	occurred at the time stigation, in my opi	date and place	and due to the o	rause(s) and manner as	stated. o the cause(s)
@ CV @ D	0				29c. License		2	29d. Date signed (Month,	Day Year)
Divi	Med	29b. Signature and title of certifier			O.C.	M.E		MAY $15, 3$	2004
To the within 2 To the complet		· anetz:	cause of death /Item 5	23a) (Tuna D	0.C.	M.E		MAY 15, 2	2004
To the within 2 To the complet		29b. Signature and title of certifier   OULE  30. Name and address of person who completed  ANA KUBIO, N			O.C.		re, Mar	MAY 15, 2 yland 21201	2004

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			1. Decedent's Name (First, Mic	dle, Last)								2. Date of Deat	1		3. Time of Death
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	Funeral		5. Social Security Number	6. Sex		ige (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
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Division	l or Atten after deat Director: I in by the	ific	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	d not be mined	28e. Place of In	njury - At h	ome, farm, str	et, factory	, office		:	28f. Location (Str. City or Town,	et and Num	ber or Rura	al Route Number,
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	To the Hospital or Attent within 24 hours after deat! To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one)	ing Physi al Examin	cian: To the bes er: On the basis and manners	of examina	wledge, death tion and/or inv	occurred restigation,	at the tim in my op	e, date and inion, deat	place, a	and due to the car ed at the time, da	use(s) and m	anner as s and due to	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certi	fier 1	11			29c	. License	number		29	d. Date sign	ed (Month,	Day, Year)
			V11101	(41	10011				)34	182	7		5-/m	104	
	. 0		30. Name and address of person	on who con	npleted cause of	death (Iter	n 23a) (Type.						-/-	1	
	10		JAMES FE	ELI	N7. MI			SEDS	DR	. Sui	TE	202 To	WSON	I.MD	21204
	Sta		31. Date filed (Month, Day, Yes	ur)	YUL Z	trar's Signa	ature							/	
	Registr	ar	N	AY 1	8 2004	Bene	see to	A	Sec.	8					

		•	For State Registrar	State of M		/ Depa		t of H	ealth a		ental Hy	giene	2004	157	805
ı	Physicia		1. Decedent's Name (First, Middle, Last								2. Date of De Month May 17	ath Day		3. Time of 2:00	Death a.M.
	/Medic Examin		Harry S. Sherman 4a. Facility Name (If not institution, give 3500 St. Jame	street and number)	!				Location o	of Death	110y 17		County of Deet Baltim	h	
	Funeral Director			7. Ag	ge (In yrs. last 77	birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month Da April	th 27, I	9. Birt 927 Mar	hplace (State of untry) yLand	or Foreign
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimor		10c. City, T	own or Lo								10d. Inside Ci	
	with the ? 3a or 28a-	i Director	10e. Street and Number 3500 St. Jan				10f. Zip	Code 244				10g. Cit	tizen of What Co	-	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "refurel", or Items 23a or 28a-f show amportant: if item 27 is marked other than "refurel", or Items 23a or 28a-f show appring yor other traumatic event, it a Marical Eval in at must be notified at an once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ XMarried  3 □ Wido wed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 K If Yes, Give Year or Dates:	?		Was Deced f Yes, spec			gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	1-	14. Race - Ame Black, White Specify: Wh:	e, etc.	
Maryland 21215-0036	d within 72 ho giene. ir than "netur: If a Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			(Give life. I	dent's Usua kind of wor DO NOT us achin	rk done d se retired)	uring most		ng		ind of Business/one Quar	ŕ	
yland	ould be file Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Harry S. Sherma	n, Sr.							(First, Middle, tansbu		n Surname)		
, Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (T) Ruth M. Sherman			3500	St.	Jame		, Ba	lto.,	Md.			
Baltimore,	Pages 1 ment of H ant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		etery, cren	sition (Naminatory or of remat	ther place	May 1		2004		cation - City or timore,		ınd
Balt	Depart Depart Import any in		21. Signature of Funeral Service Licens	audt			11605	rdt Rei	Funer	ral C	hapel,	Owin	gs Mill		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or leart failure. List only ol Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as	c C / N.	om a ice of):		-00				rrest,		Approximate Interval Bette Onset and I	ween
760	icate be executed physician and s the burial-transit	icai Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	a consequen										
P.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pro						23d. Date of deli	,	/ear
	quires that n signed b uld be deta		Part II. Other significant conditions co			•	, ,	ause give	n in Part I.			obacco u	use contribute to □No 3□Pro	the cause of d	
Vital Records,		Completed	Diabetes	M	ell	tu	<u></u>				24a. Was autop perfo 1 Yes		death?	topsy findings a completion of ca	available ause of
Vita	Physician: this certificanal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpati	ent 2□ER	/Outpatien	t 3 🗆 DO	A Othe	~		(Check only o		6 □Other (Spec	ify)	
ion of	Attending Phirdeath. ector: After thi	ertification: T	27. Manner Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ıry 28	b. Time of Injury		8c. Injury Work	at	2	8d. Describe h				
Division	el or Atte s after de: al Directo ad in by th	Certific	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home tc. (Specify)	, farm, str	eet, factory	, office		2	8f. Location (5 City or Tox	Street an vn, State	nd Number or Ru b)	ral Route Num	ber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 12 Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner st	of examination	dge, death and/or inv	estigation,	in my op	inion, deat	d place, a th occurre	d at the time,	date and	d place, and due	to the cause(s	)
)	with To 1	Σ	29b. Signature and title of certifier	-HC	inde		2	. License					te signed ( <i>Month</i>		
	7		30. Name and address of person who consume H Ginsberg	, M.D.	8630 Li	ibert	•	za M	a11	Rand	allsto	wn,	MD 21133	3	
4.	Sta Registr		31. Date filed (Month, Day, Year) MAY 1	32. Regist	rays Signature		Low	W)	4						

ysicia		State Registrar  1. Decedent's Name (First, Middle, Las	t)	Cei	rtificate of	Death	Ra 2. Date of Death	g. No. 200	3. Time of Death
Medic	an	Dorothy W					May 14		5:30 p <sup>M</sup>
xamin	er	4a. Fecility Name (If not institution, give Golden Crest Nur				or Location of Death stminster	ı	4c. County of De	
neral ector		22 1430-3773	ox 7. Age (In y ☐ M 2 TyF 92	rrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 18	9. E 1911 N	Birthplace (State or Foreign Country) Maryland
Iffed at		Usual Residence of Decedent  10a. State 10b. County  Md. Carroll		City, Town or Lo					10d. Inside City Limits 1 1 Yes 2 □ No
theng	i Director	10e. Street and Number 811 Fairfield	Rd.		10f. Zip Code 21	.157	10	g. Citizen of What	Country?
any injury or other treumatic event, It.e Medical Examinar runt be traffilled at ODGs.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi Specify: W	
re Medical E	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire Advertis	during most of word)	king 1	6b. Kind of Busines	·
itic event,	To Be Co	17. Father's Name (First, Middle, Last)  Grant E. Mentz	el			18. Mother's Nam	ne (First, Middle, M	aiden Sumame) Williams	
treum		19a. Informant's Name/Relationship (7 Charles R. Senn		on 4440	w. Canal	and Number or Ru Rd., Do	ral Route Number, Ver, Penn	City or Town, State sylvania	17315
or other		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐	20	b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	сө)	Date 2	Oc. Location - City	
injury c		4 □ Donation 5 □ Other (Specify  21. Signature of June al Sente Licen	) W				, 2004 W		Maryland
è d		1 Hy Zel	healt		3296 Cha	rmil Dr.	Chapel, Manches	ter, Md.	21102
ician dical		23a. Part1. Enter the disease, or companies, or hart failure. List only disease or condition resulting in death)	Carolin	mayora	er the mode of dyi	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. A C VID  Due to (or as a con  Due to (or as a con  Due to (or as a con	sequence of):	age				25 yrs
ne bui	edicai		d23c. If yes, outcome of pre	gnancy				23d. Date of c	
hed for use as th	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3 [	Ectopic pregnanc Other (specify)	у	<del></del>	Month	delivery Day Year
gred by the attending property of detached for use as t	d by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal déath 3 [ of death 5 [	Other (specify)			acco use contribute	
ite nas been signed by the attending proage 2 should be detached for use as t	by	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal déath 3 [ of death 5 [	Other (specify)		1 Yes  24a. Was an autopsy perform	24b. Were prior t	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available o completion of cause of
Arier tris cutilicate has been signed by the atlenting profuneral director, page 2 should be detached for use as t	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 F4 4 Pregnant at time 9 Unknown  ontributing to death but not  Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea.	etal death 3 of death 5 of death 6 of death	Other (specify) _  nderlying cause grant 3 DOA Other	ven in Part I.  26. Place of Dea	1 Yes  24a. Was an autopsy perform	24b. Were prior to death 1 1 Y.	Day Year  to the cause of death?  Probably 4  Unknown  autopsy findings available o completion of cause of ?  s 2 No
organism and the state of the s	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions of the past 12 months?  25. Was case referred to medical examiner?  1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown  ontributing to death but not  Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day Yea.)	resulting in the u  ER/Outpatier  2 ER/Outpatier  2 Sb. Time o  Injury	Other (specify) _  nderlying cause gr  nt 3 □ DOA Other  28c. Inju Wo M 1 □	ven in Part I.  26. Place of Dea  1917 4 □ Nursing H ry at	24a. Was an autopsy perform  1 Yes 2 th (Check only one ome 5 Resider 28d. Describe how	24b. Were prior to death 1 1 You injury occurred	Day Year  to the cause of death?  Probably 4  Unknown  autopsy findings available o completion of cause of ?  s 2 No
organism and the state of the s	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1   Inpatient : 28a. Date of Injury - A 28e. Place of Injury - 28e.	resulting in the u  ER/Outpatier  2 ER/Outpatier  28b. Time of Injury  At home, farm, strecity)  knowledge, deati	Other (specify) nderlying cause gr  nt 3 DOA Ct f 28c. Inju Wo M 1 == eet, factory, office	26. Place of Dearer 4 Nursing Hry at rk? 1 Yes 2 No	24a. Was an autopsy perform  1 Yes 2  th (Check only one ome 5 Resider 28d. Describe how 28f. Location (Street, City or Town, and due to the cat.	24b. Were prior to death 1 1 You injury occurred  set and Number or State)	Day Year  I to the cause of death?  Probably 4  Unknown  autopsy findings available o completion of cause of ?  as 2  No  Decify)  Ussisted  Rural Route Number,  as stated.
Arier tris cutilicate has been signed by the atlenting profuneral director, page 2 should be detached for use as t	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inpatient :  28a. Date of Injury (Month, Day Yea)  28e. Place of Injury obuilding, etc. (Sp. ysician: To the basis of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of examples of the pass of the pass of examples of the pass	resulting in the u  ER/Outpatier 2 ER/Outpatier 7) 28b. Time of Injury At home, farm, strecity) knowledge, death	Other (specify) nderlying cause grant 3 DOA of 28c. Inju Wo M 1 reet, factory, office h occurred at the tivestigation, in my of	26. Place of Deaner: 4 Nursing Herral Nursing Herral Yes 2 No	24a. Was an autopsy perform 1 Yes 2 th (Check only one ome 5 Resider 28d. Describe how 28f. Location (Street, City or Town, and due to the carried at the time, date 29	24b. Were prior to death 1 1 You winjury occurred  set and Number or State)  Use(s) and manner e and place, and d. Date signed (Mo.	Day Year  I to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of ess 2 No  Decity) Ussisted  Rural Route Number, as stated. ue to the cause(s)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible For State Registra Decedent's Name (First, Middle, Last) Physician Ibrahim Hanna /Medical 4a. Facility Name (If not institution, give street a Examiner Baltivius If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Aug. 21 MOGPITAL

If Yes, Give Year or Dates:

/ Son

7. Age (In yrs. last birthday)

61

10c. City, Town or Location

Reisterstown

10f. Zip Code

16a. Decedent's Usual Occupation

Manager

28 Bensmill Court

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

Al-Fuheis Cemetery

1 ☐ Yes 2 No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

21136

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Zarefa

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Of I fill the old on the	actible link. Elibate Al	oopies A	re Legit	JIC.		
te of Maryland / Depa Cea	artment of Health and Martificate of Death		ene 2 (	004	15	807
eh Tadros		2. Date of Death Month	Pay Z	Xear OO4	3. Time of 251	Death PM
nd number)	4b. City, Town, or Location of Death		4c. County	of Death		

**Funeral Director** 

Direct à Be

Maryland 21215-0036

Baltimore.

P.O.

Records,

Division of Vital

Physician /Medical Examiner

Attending ō the ert

Good Samaritan 6. Sex 1 M 2 □ F Social Security Number 320-46-5177 Usual Residence of Decedent 10a. State item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Maryland Baltimore Co. 10e. Street and Number 28 Bensmill Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7 yrs. 17. Father's Name (First, Middle, Last) 2 should be fi Hanna Tadros 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trau Mr. Steve Tadros 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Michael E. Canapp Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit physicien certificate be Physician/Medical as the t IF FEMALE for use 23b. Was decedent pregnant in the past 12 months? detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Pe Completed peen page 2 s nas certificate 25. Was case referred to medical director Be 2 1 Yes 2 No this Alter this funeral of 27. Manner of Death Certification: 1 Natural 5 Pending hours after death. investigation 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide filled in by 4 Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Baltimore, MD 21214 <u>Leonard J. Ruck, Inc.</u> 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myouaraia Due to (or as a consequence of) vaccular Disease Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown

> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 2 🖳 🕅 o 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D 15135 29d. Date signed (Month, Day, Year)

Birthplace (State or Foreign Country)

Pálestine

10d. Inside City Limits

1 Yes 2 No

1942

10g. Citizen of What Country?

Specify

U.S.A. & Jordan

16b. Kind of Business/Industry

Unknown

20c. Location - City or Town, State

5305 Harford Road

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown

Micheal

May 20, 2004 Al-Fuheis, Jordan

Reisterstown, MD

18. Mother's Name (First, Middle, Maiden Sumame)

14. Race - American Indian

White

Black, White, etc.

person who completed cause of death (Item 23a) (Type, Print)

Scott MD 5601 LOCH ROLVEN BIVD. Baltimore, MD 21239 enelope 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

	1	For Amend Item 19b per Registrar  1. Decedent's Name (First, Middle, Last,			irtment of tificate of	Health a		ntal Hy	neg. 140 (	004	3, Time of 20	<u> </u>
Physicia /Medica	al -	RUTH L	SONDITE	m	4b. City, Town,	or Location	0	nA4	09 8	Yeer 2004 nty of Death	2:101	Рм
Examine		Ha. Facility Name (If not institution, give	LOSPITAL		RAF	MALL	570 W		B	ALTI	MORE	
Funeral Director				s. last birthday) 95 Yrs.	If Under 1 Year Months Day		24 Hrs. 8.	Date of Birt (Month, Da PR. 30	, 1909	9. Birthp Cour	lace (State or F htry) MD	oreigr
ehow		Usuel Residence of Decedent  10a. State 10b. County		ity, Town or Lo						1	0d. Inside City	
death with the Maryland ms 23a or 28a-f ehow	ector	MD BALTI	MORE	BALT	IMORE				10g. Citizen o	of What Cour	1 ☐ Yes 2	¥ No
23a or 3		725 MT. WILSON LA	NE, #517		101. Zip 000a	212	08		rog. Omizorro		U.S.A.	
or Ite	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 1 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 💢 N			y Yes or No an, etc.)	14. Ri Bi	ace - Americ lack, White, cify:		
within 72 hours iene. 'than "natural', I'm Medical Exa	Completed	15. Decedent's Edit (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life. I	lent's Usual Occ kind of work don DO NOT use reti	upation le during mos red)	st of working		16b. Kind of		dustry	
e tiled y al Hygie other i	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>	ILAU	HEN	18. Mothe	er's Name (F	irst, Middle,	Maiden Sumi			
2 should be and Mental is marked o	To B	DANIEL		LOWENTH		1	AISY				RLINER	
nd 2 shi alth and 27 is m ir traum	000000000000000000000000000000000000000	JUDY KRAMER / DA	/рө, Print) NU-IN-LAW		ng Address <i>(Str</i> e GALWAY I						07017	
ë ° = 5		20a. Method of Disposition  1 🕅 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State		sition (Name of natory or other p HEBREW		Date 5/16/2		20c. Location	n - City or To		
permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licens	99		. Name and Add				SON & E PIKESVI			8(
Pnysician /Medical		23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		NEV	er the mode of d		cardiac or r	espiratory a	rrest,		Approximate Interval Betwe Onset and De	en ath
Examiner	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	equence of):	221							
le be ysicia e bui	Icai Examiner	Cause (Cisease of Injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):								
Attanding Physician: The law requires that the death certificate rideath.  actor: Atter this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ★ ○ 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnar Other (specify)					Date of delive	ery Day Yea	ar
w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause	given in Part I	l. 		obacco use co ∕es 2□No		ne cause of dea	
: The law recate has been page 2 sho	Completed							24a. Was autop perfo 1 🗆 Yes		b. Were auto prior to co- death? 1 🗌 Yes	psy findings av mpletion of cau 2 No	ailable se of
nysician: Th nis certificate I director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 12 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	)ther		Check only o	<i>ine)</i> dence 6 □C	ther (Specif	v)	
ding Phy	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	The second second	Sugar ap a			now injury occ		//	
r Attandin ter death. iractor: At iractor At	Medical Certification;	1 Satural 5 Pending investigation 3 Suicide 4 Homicide Pending investigation 6 Could not be determined		home, farm, str	M 1	□Yes 2□		Location (S City or Tox	Street and Nur vn, State)	mber or Rura	I Route Numbe	)F,
To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the it	ical Ce	(Check only 2 Medical Exem	vsicien: To the best of my ki									
To the within 2 To the complet	Med	29b. Signature and illurar certifier	and manner stated.		29c. Lice	inse number	13.		29d. Date sign	ned (Month)	Day, Year)	4
di		30. Name and address of person who c	completed cause of death (It	em 23a) (Type,	Print)	NO 19	HW	£35	COVR	SCITP TRO	ADMO	77 211
Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 8 2004	32. Registrar's Sig		books							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004

15809

									Ce	rtificat	e of	Deat	h		Reg. I	No.			0000
				1. Decedent's Nam	e (First, Middle	, Last)								2. Date of I		Davi	V	3. Time	of Death
	П	Physicia			7	T								Month	1	Day	Year	12:	30am
	1	/Medic		4a Facility Name (i		Terrar						4b. Citv.	Town, or Lo	May ocation of De	ath	1_20 ( 4c. County	of Deeth	1	
•	-2	Examin	er									,,	_						
				Stella						If Under	1 Voor	If I lod	TOW ler 24 Hrs.	son	17.41		timo		F !
		Funeral		5. Social Security N		6. Sex 1 ☐ M 2 ဩ			ast birthday)	Months		Hour		8. Date of E (Month, I	Dey, Ye	ar)			e or Foreign
		Director		217-09-4	4988	10 101 204		88	3 Yrs.					Apri	3,	1916	Mar	ylan	d
		D		Usual Residence of				1										0.1.1.11	
		yler y		10a. Stete	10b. County			10c. City	, Town or L	ocation									City Limits
		W T	ō	MD	Balt	imore				$\mathbf{E}$	sse	X						1 🗆 Y	es 2 🗵 No
		1 28 E	Director	10e. Street and Nu	mber					10f. Zip	Code				10g.	Citizen of	What Cour	ntry?	
		with with	△	502 Alr	nond A	V/O					212	21			ī	JSA			
		filed within 72 hours after death with the Marylend Hygiena. ther than "natural", or items 23s or 28s-f show ent, the Medical Examinat must be notified at	Funeral				Decedent	Ever in 11	S 12				Origin? (Sp	ecify Yes or I			e - Americ	an Indian.	
		ap and	Š	11. Marital Status		Arme	ed Forces?		J. 15.	If Yes, spec	cify Cub	an, Mexi	can, Puerto	ecify Yes or I Rican, etc.)	10		ck, White,		
•	20	a a		1 Never Marr	_	ed 1 1	res 2√2]! s, Give	NO		1 ☐ Yes	2 <b>X</b> No	Speci	ity:			Specifi	.Whi	te	
a.m	Š	ino in in in in in in in in in in in in in	d b	3 ₩ Widowed	4 L Divorced	Year	or Dates:								1	1			
a	5-0020	72 h	Completed	(Spec	15. Decedent city only highes	s Education t arade comple	ted)		16e. Dece (Give	dent's Usua kind of wo	al Occup rk done	oation du <i>ring m</i>	ost of work	ing	16b	. Kind of B	usiness/In	dustry	
:30	21	thin thin	횰	Elementary/Seco		1	ge (1-4or !	5+)				d)							
~	2121	d with giena. r thar	듓	6th					Hom	emak	er					own l	nome		
12	O	ould be filed Mental Hygi arked other atic event,	Be	17. Father's Name	(First, Middle, L	.ast)						18. Mo	ther's Name	e (First, Midd	le, Maio	len Surnan	ne)		
	a	id be ental ced o c ev	ToB	Dano	oto Ma	zzola						Lı	ıcia	Pagli	a				
4	2	2 should end Men is marke aumatic	-	19a. Informant's N			)		19b. Maili	na Address	(Street	-		el Route Nun		ty or Town.	State, Zig	Code)	
2004	Marylan	hen her ris																	
2		1 end Heelth em 27		Joan Ko		daugnt	er	20h Pi	lace of Disp			Q A	ve. E	Baltin Date		Location			
Ι,	0	S = 0			Cremation	3 □Removal f	rom State	CE	emetery, cre	metory`or o	ther pla						,		
11	Ē	nit. Pag artmant ortant: Injury o			5 ☐ Other (Sp			Oa	akLaw	nCem	ete:	ry	1	5/15/	04	ватт	1 mo	re M	ט
MAY	Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Fu	neral Service L	icensee		1	1 2	2. Name ar	d Addre	ss of Fa	cility Co	nnel	νFι	iner	alHo	meof	Essex
$\mathbf{Z}$	m	Dep impo	- 7	<b>▶</b> // -	1001	1/1/				3.0	ΩМ	ace		Balt	- 170				2
	-	-		23a Perti Enter I	ne disease or	Complications t	7111	the death	Do dot en								-	-	nate
82	-			23a. Part1. Enter t shock, or hea	art failure.	y one cause	on each li	ne.	1		-, -, -			,				Approxin Interval E Onset ar	Between nd Death
•		Physician			/Final				60										
332	7	/Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	e Li	UNG C	ANCER	}								÷		
		Laginini		resulting in death)				Due to (or	r es a conse	quence of):									
		₽ ≃	ne			6											ı İ		
		certificate be executed iding physician end ise es the burial-transit	Examiner	Sequentially list co	onditions,	D		Due to (or	as a conse	quence of):									
	ó	an e		if any, leading to in ceuse. Enter Under	nmediate erlying														
	68760,	sicil	/Medical	Sequentially list co if any, leading to in ceuse. Enter Under Cause (Disease or that initiated events	injury	c		Due to (or	as a conse	quence of):									
	68	fical g phy ss th	8	resulting in death)	Last	1		•									i		
Vz	Вох	ding use est	\$			d													
X	ğ	atter for u	Physician															**	
	o.	the d	ysi	Part II. Other signif	ficant condition	ns contributing	to death b	ut not resu	iting in the i	inderlying d	ause gr	ven in Pa	ıπ I.						e of death?
	σ.	d by detac	듄											11	Yes	2□ No	3 □ Pro	bably 4	Unknown
	Ś,	The law requires that the daath ate has been signed by the atter page 2 should be detached for u	ρ																
	Record	en s ould	8											24a. W	as an au rformed		av	ailable pri	sy findings or to
VA	ပ္ထ	s be	음														of	mpletion of death?	or cause
9	æ	he la e ha	Completed											1[	Yes	2 No	1[	∃Yes 2	!□ No
₹	a			25. Was cese refer	red to medical							ae pi	and of Doot	h (Check onl		-A.	1		
TERRANOVA	Vital	nysician: The law nis certificate has t I diractor, page 2 s	Be	examiner?		Hospital:			-0:0 : ::		Oth	hor:				- <b>Y</b> 1011	(0	HOC	DICE
H	<del>o</del>	Physician: r this certific ral diractor,	2	1 ☐ Yes 2 X			1 Inpatio		ER/Outpatie 28b. Time of		JA	4	Nursing Ho	me 5 Re 28d. Describ			ner (Specif	y) HUS	FICE
Z		ffer the the	0	1 XNatural	5 Pending		Date of Inju (Month, Da	y Year)	Injury		28c. Inju			Edg. Describ	0 11044 11	nary occur	100		
ANN	<u>Ş</u>	Attending in death.  • ctor: After by the fune	at	2 Accident	investig					М		Yes 2	□ No						
	Division	or Attending I aftar death. Director: After I in by the funer	Ĕ	3 ☐ Suicide 4 ☐ Homicide	determi	ned 289. h	Place of Injouitding, et	jury - At ho c. (Specify	me, farm, st	reet, factor	y, office			28f. Location City or 7			ber or Rura	al Route N	um <i>ber</i> ,
			Certification:																
		Hospital 24 hours Funeral staly filled	ie i	29a. Certifier	1X Certifying	Physician: T	o the best	of my know	wledge, deat	h occurred	at the ti	me, date	and place,	and due to th	e ceus	e(s) and m	anner as s	tated.	- (-)
		Ho Fu Fu	edical	(Check only one)	2  Medical t	xaminer: On t	manner st	t examinat ated.	ion end/or ir	ivestigation	, in my c	opinion, c	leath occur	red at the tim	e, date	and place,	and due to	o tne caus	e(s)
		To the Hospital within 24 hours To the Funeral complataly filled	¥ e	29b. Signature and	title of certifier		7			290	c. Licens	se numb	эг		29d.	Date signe	d (Month,	Day, Yee	7)
		F > F ŏ					/_			1	DI	37	7-(			5	/11/	611	
1		0		•			11.		\ :-		ال ال	J /			L	0	111	7	
			)	30. Name and addr			cause of c	seath (Item	23e) (Type	, Print)						/	/	,	
				DR. TAR		100D 2			Y VAL	LEY R	D	TIMO	MUINO,	MD 21	093				
		Sta	te	31. Dete filed (Mor		3	32. Registr	rar's Signal	ture	1	1								
	24	Registr	ar	21178	Y 11 & 20	U4: 1/C	u. w	-	N	Span	Cal								

		•	For Stete Registrar	State of Maryland /	Department of Healt  Certificate of Dea	th and Mer ath	ntal Hygiene Reg. No.	2004	15810
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	THOMAS			Date of Death Month Day	Yeer	3. Time of Death 4:15 A M
	Examin Funeral Director	er	did-12-6020	treet and number)  DVDOU SHOWN  A ge (In yrs. last b)	4b. City, Town, or Locat  ROULE  inthday) If Under 1 Year If U	allstov	Date of Birth (Month, Day, Year)	Sounty of Death  9. Birth	IMOVE place (State or Foreign ntry)
	Maryland a-f show	ctor	Usuel Residence of Decedent  10a. State 10b. County  Battin		vn or Location Rayral 15to	UNN	/ / /		10d. Inside City Limits
	th with the 23a or 28	Funeral Director	4105 Hanwell	Road	10f. Zip Code	33		izen of What Cou	
5-0036	72 hours after death with the Maryland natural', or Nems 23a or 28a-f show disal Examiner must be nullified at	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  O If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specify xican, Puerto Rica ecify:		14. Race - Ameri Black, White, Specify:	
21215-0	is 1 and 2 should be filed within 72 hours after dea of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner in	Completed by	15. Decedent's Edu (Specify only highest grade		a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) HOMEMS K	most of working	16b. Ki	ind of Business/Ir	dustry
Maryland 2	ould be filed I Mental Hygid Parked other	To Be C	17. Father's Name (First, Middle, Last)	Gladden	18. M	Lottie	irst, Middle, Maiden 2 HOW	KINS	
	s 1 and 2 sh f Health and item 27 ls m other traum		19a Informant's Name/Relationship (Ty  20a. Method of Disposition	(Daughter) 4	b. Mailing Address (Street and No of Disposition (Name of ery, crematory or other place)	Date	Randalt	ocation - City r T	no 21133
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at ODGs.		1 Surial 2 Cremation 3 F	Cray	SVILLE VA 22. Name and Address of F 8728 Liber	5-19-	04 Cra hncGred hnchilsti	unsville Inc Fun	e MD Inal Service 20132
×	Physician		23a. Part 1. Enter the disease, or complishock, or heart failere. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do	not enter the mode of dying, such	h as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
8760,	eath certificate be executed attending physicien and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	at Hyper	tensi marca tule	00 1 wal		
P.O. Box 6	0 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past, 12 months? 1  Yes	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	h 3 DEctopic pregnancy 5 Dother (specify)			23d. Date of deliv Month	ery Day Year
	w requires that the been signed by th should be detache		Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in P	Part I.	23e. Did tobacco u		he cause of death?
Vital Records,	The la ate has page 2	Completed by					24a. Was an autopsy performed? 1 Yes 2 No	prior to co	opsy findings available impletion of cause of
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ ER/C	Other	Place of Death (C	theck only one) 5 ☐ Residence	e Flother (See	185 W
Division of	ding After fune	H .	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Time of Injury M 1 Yes	28d	. Describe how injur		(9)
Divis	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f.	Location (Street an City or Town, State		al Route Number,
	To the Hospital or Ai within 24 hours after or To the Funeral Direc completely filled in by	Medical	(Check only 2 Medicel Exami	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ind/or investigation, in my opinion,	, death occurred a	at the time, date and	place, and due t	o the cause(s)
	on to	W	29b. Signature and title of certifier	3 Krevaln	29c. License num	753	2 Sad. Dat	te signed (Month,	Doy, 1641)
	10		30. Name and address of person who co	mpleted cause of death (Item 23a	Road Si	inte?	300,0,1	Cosul!	16 Mostle
	Sta	ate	31. Date filed (Month, Day, Year)	Tegistral s Signature	Anale)				21500

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrer	State of	Marylan		artmen			and M		Reg. No.	04	15811
I	Physici /Medic		1. Decedent's Name (First, Midd			mpse					2. Date of Dea	19 a	Year 009	3. Time of Death
	Examin	er	117111001	OSPITAL C	ENTE		4b. City,	42T/	Location of	E		4c. County		
ŀ.	Funeral Director		5. Social Security Number 216-01-0828  Usual Residence of Decedent	6. Sex 1 → M 2 □ F	'. Age (In yrs. 91	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Dec . 18	1912	9. Birthp Cour MD	place (State or Foreign ntry)
	aryland show	J.	10a. State 10b. County		10c. Cit	ty, Town or Lo								10d. Inside City Limits
	the M	recto	MD Anne  10e. Street and Number	Arunde1		Linth	10f. Zip	Code				10g. Citizen of V	What Cou	
	h with 23a or st be	ai Di	26 Patapsco Ro	ad				210	90			U	.S.A	•
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23s or 28s-f show or other treumatic event, the Medical Examinar must be notified at	l by Funeral Director	11. Marital Status  1 Never Married 2 Mai  3 Widowed 4 Divorce	12. Was Deced	ces? 2. [XNo		Was Deced If Yes, spec 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Americk, White,	
5-0	72 hc	etec		nt's Education est grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition Juring most	t af work	ing	16b. Kind of B	usiness/In	dustry
2121	d within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		t Meta					Heatin Condit		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, I'le Me	To Be C	17. Father's Name (First, Middle)  David M. Tho								e (First, Middle, Ruth Ta	Maiden Suman wney	ne)	
Mary	d 2 sho th and I 7 Is ma treume		19a. Informant's Name/Relation									or, City or Town,		Code)
	of Heal item 2		Mr. Grant L. Th			IZI I Place of Dispo cemetery, crei	sition (Nam	ne of			Date	MD 2128 20c. Location -		own, State
Baltimore,	Page tment tant: If fury or		1 X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (	Specify)	tate	dar Hi	11 Cer	nete	ry M			Brookly	-	
Ball	permit. Pages 1 and 2 Dep rtment of Health a Important: If item 27 li any injury or other tre 2005e.		21. Signature of Fineral Service	oully	ma	319 1	Secon	nd A	venue	S.W	., Clen	Funeral Burnie		
	Physician /Medical		23a. Fart1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on ea	used the deat ch line. TEST VE ras a conseq 10374	e He	ast	Fair		cardiac	or respiratory ar	rest,	á	Approximate Interval Between Onset and Death
3760,	ate be executed wysician and wysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	r as a conseq	uence of):	EMA			Poss			0	days.
P.O. Box 68	that the death certificate be executioned by the attending physician and detached for use as the burial-tran	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta int at time of d	Ideath 3	Ectopic pro					23d. Dat	e of delive	ery Day Year
	Se Se		Part II. Other significant condit  Diabeles Me	ions contributing to dec		ulting in the u		use give	n in Part I,		23e. Did to	/		ne cause of death?
Il Records,	The law ate has b page 2 st	Completed by	Colonary &	stery D. dum	iseasc	, Ken	nal	lnsc	Ati ces	nig,		med3/	prior to conteath?	psy findings available impletion of cause of 2 No
Vita	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:	_			Othe	pr-		Check only o			
Division of Vital	ng Phys Iter this Ineral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest	28a. Date o		28b. Time of Injury		Bc. Injury Work	4 🔲 Nui			ence 6 Other		у)
Divisi	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 □ Could	not be 28e. Place	of Injury - At h	ome, farm, str	eet, factory	, office			28f. Location (S City or Tow	itreet and Numb n, State)	er or Rura	l Route Number,
	To the Hospite within 24 hours To the Funere completely fille	edical (	29a. Certifier 1 Certifyi (Check only 2 Medice	ng Physician: To the la Exeminer: On the ba and mann	sis of examina	wledge, deati	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the ded at the time, d	cause(s) and ma date and place, a	nner as si and due to	ated. the cause(s)
	To t To t	Me	29b. Signature and title of certifi	In m	. D .	PGYI	290	License	number	85		29d. Date signed ,	(Month.	Day, Year) 2004
100	10		30. Name an inddress of person HARIS ALI	who completed cause $\beta \circ \beta \circ \alpha = S$	of death (Item	n 23a) (Type,	Print)	B	alton	nere	mo	May,	5	
Ì	Sta Registi	-	31. Date filed (Month, Day, Year MAY 1 8 20		gistrar's Signa		por	2						

State of Maryland / Department of Health and Mental Hygiene 000 1

5	8	2
-		Brown

				1 - State Registrar					C	ertific	ate of	Deat	th		Reg. N	0.		
				1. Decedent's Name (First, Mi	ddle, La	ast)								2. Date of D			V	3. Time of Death
		Physici		ANNA		VESEK								MAY 15	5 <b>,</b> 20	04	Yeer	8:50 P M
		/Medic Examir		4a. Facility Name (If not institu	ition, giv	e street and n	umber)			4b. (	City, Town, o	or Locatio	on of Death		4	c. County	of Death	
		Exami		STELLA MAR	IS NU	JRSING HO	ME				TIMO	NIUM				BAI T	IMORE	
		Funeral		5. Social Security Number	_	Sex		(In yrs. la	st birthda		nder 1 Year	If Und	ier 24 Hrs.	8. Date of B	irth	T		place (State or Foreign htry)
		Director		169-07-8611		1 M 2 XX		90	Yrs.	Mon	ths Days	Hour	s Min.	(Month, E		7)		NSYLVANIA
2				Usual Residence of Decedent														
<u> </u>		/land		10a. State 10b. Cou	nty			10c. City,	Town or	Location							1	10d. Inside City Limits
50 pm		Man,	ō	MARYLAND BA	ALTIM	10RE			TIMO	MUIN								1 ☐ Yes 2 XXNo
43		the 28a	Director	10e. Street and Number						10f	. Zip Code		****		10g. C	itizen of V	/hat Cour	ntry?
0		death with the Maryland ims 23a or 28a-f show Ir must be notified at		2300 DULANEY VA	LLEY	ROAD					2	1093				U.S	.A.	•
•		after death w or items 23a	era	11. Marital Status		12. Was De	cedent E	ver in U.S	6. 13	3. Was D	ecedent of h	Hispanic (	Origin? (Spe	cify Yes or N	0-	14. Race	- Americ	can Indian,
	4.0	iter o	F.	XX Never Married 2 1	Married	Armed F	orces? 2 <b>XX</b> No			If Yes,	specify Cub	an, Mexi	can, Puerto F	Rican, etc.)		Blac	k, White,	
5	38	ars a	þ	3 ☐ Widowed 4 ☐ Divor		If Yes, G Year or	ive			1 □ Ye	s XX No	Spec	ify:			Specify	· WH	ITE
hoot	21215-0036	72 hours after natural', or ite dical Examine	Completed by Funeral	15. Dece	dent's E	ducation		Π	16a. Dec	cedent's	Usual Occup	pation			16b.	Kind of Bu	siness/In	dustry
7	15	n'n'n	ple	(Specify only hig Elementary/Secondary (0-1			) (1-4or 5+		(Gr life	ve kind o . DO NO	f work done Tuse retire	during m id)	nost of workin	ng				
	212	e filed within al Hygiene. I other than "	E	12	-/	Conege	(1-401-54	'		SECRE	TARY				HOI	ME CAR	E PRO	VIDERS
5	D	filled Hygid other ent, II	BeC	17. Father's Name (First, Mide	de, Lasi	t)						18. Mo	ther's Name	(First, Middle	e, Maide	n <i>Sum</i> am	ө)	
-	Maryland	2 should be and Mental is marked o	To B	MICHAEL VESEK									ANNA TI	KACH				
	>	shound M	-	19a. Informant's Name/Relati	onship /	(Type, Print)			19b. Ma	iling Add	ress (Street	and Nun		Route Num	ber, City	or Town,	State, Zip	Code)
20	N	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tre Medical Exertirer must be notified at		STEPHEN J. VESI	FK . S	iR.								LL, MARY				
2	ā,	Hea Hea tem othe		20a. Method of Disposition 20b. Place						position	(Name of			ate	_	ocation -		own, State
Ma	2	0 ゅうきゅ 1									or other pla		MAY 20	2004	В	<b>OSWELL</b>	. PEN	NSYLVANIA
		STEPHEN J. VESEK, SR.  20a. Method of Disposition  1							1	22. Nam	e and Addre	ass of Fa	i	FUNERA				
	Ba	Departing important					04460							LEN BURN				
		-		23a. Part1. Enter the disease			01148 caused t	he death									<u>,                                     </u>	Approximate
_				shock, or heart failure.	List only	one cause on	each line	9.	DOTION		t ayı	ng, saon	as cardiac of	respiratory	arrost,			Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition		a. MU	RIC	du	150	195	19							
		/Medical Examiner		resulting in death)		Due t	(or as a	conseque	ence (i):									
		LAdillilei	L	Sequentially list conditions,	- 1	b. Pa	inc	410	pe	Ma								
		p #	Examiner	cause. Enter Underlying Cause (Disease or injury	1	the to	for as a	conseque	erice of it								- 1.	
. /		acute and trans	am	that initiated events resulting in death) Last	1	c												
X	Ő,	e exe		resulting in deathy Last		Due to	o (or as a	conseque	ence or):									
V	68760	certificate be executed uding physician and use as the burial-transit	/Medical			_ d												
		ndific ng p	Mec	IF FEMALE:													!	
	Box	eath ce attendi for use	an/l	23b. Was decedent pregnant		23c. If yes, or 1 ☐ Live		f pregnand		3 Ectop	ic pregnanc	γ				23d. Date Mor		,
		The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by Physician	in the past 12 months?		4☐Preg 9☐Unk		ime of dea			(specify)					MOI	itti	Day Year
	P.0	at the by the	h	9 🗌 Unknown	-													
Y		as the	by	Part II. Other significant con-	ditions	contributing to	death but	not result	ting in the	underlyi	ng cause giv	ven in Pa	rt I.	23e. Did	tobacco			ne cause of death?
0	ord	w requires that been signed by should be det												1 🗆	Yes 2	2 □ No	3 🗌 Prob	abiy 4 Unknown
125e,	Records,	law re as be 2 sh	Completed											24a. Wa		24b. V	/ere auto	psy findings available mpletion of cause of
13	æ	The lav	E											perf	opsy formed? 2 X N	d	eath?	
	Vital		0	25. Was case referred to med	tical							26. Pla	ace of Death	(Check only				
ب	>	Physician: rthis certific ral director,	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)		Hospital:	] Inpatien	t 2□E	R/Outpati	ient 3	DOA Ott	200		ne 5 Res		6 X Othe	r (Specifi	HASINICA
nna	0			27. Manner of Death		28a. Date	of Injury	2	28b. Time	of	28c. Injui		_	8d. Describe	_			The spine
C	lon	oding: .: Aft	t o	1 Natural 5 Per	nding estigatio		nth, Day	rear)	Injury	M		Yes 2	□No					
I	Division	or Attending after death. Director: After in by the fune	100	3 ☐ Suicide 6 ☐ Co	uld not b	4 280. Plac	e of Injur	y - At hom	ne, farm, :	street, fa	ctory, office		2	8f. Location	(Street a	nd Numbe	r or Rura	l Route Number,
	ā	P # # □	Certification:	4   Homicide		Dulk	aing, etc.	(Specify)						City or To	own, Stat	Θ)		
		Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certi	fying P	hysician: To th	e best of	my know	rledge, de	ath occur	red at the til	me, date	and place, a	nd due to the	cause(s	s) and mar	nner as st	ated.
		P Ho	Medical	(Check only 2 Medi	cal Exa	miner: On the and ma	basis of e nner state	examination	on and/or	investiga	tion, in my o	opinion, d	leath occurre	d at the time	, date an	id place, a	nd due to	the cause(s)
_		To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	M	29b. Signature and thie of cer	tifier						29c. Licens	se numbe	er		29d. Da	ate signed	(Month,	Day, Year)
		T		) NT	-						1)48	72	-		Mo	41	6,2	004
	1	11.	) .	30. Name and address of per-	son who	completed cau	use of dea	ath (Item 2	23a) (Typ	e, Print)			^ ′			,		
	1	\		Dr Tariar	Nat	modo		300		ane	yVo	ille	4 122	TIN	1001	UM	, Ma	121093
		Sta		31. Day Miled Wenth Bay Y	()4	22 32.	Registrar	's Signatu	are	1			1			,	/	
		Regist	ell		- ·	1-1		1	13	20K	Ta/							

State of Maryland / Department of Health and Mental Hygiene [ ] ] [ 15813 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month MAY 16, 7:25a David Holcombe Walker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bel Air Harford 1332 Somerville Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

JULY 31, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs 1923 Maryland 80 219-18-0306 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or itama 23a or 28a-f show the Medical Execution must be notified at 1 ☐ Yes 2 No Harford Bel Air Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1332 Somerville Road 21015 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 110 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Heavy Construction marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, QDCB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Holcombe Walker Rebecca Newbold Mace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, MD ZIVI.
20c. Location - City or Town, State Miriam B. Walker/Wife 1332 Somerville Road Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5-17-04 Metro Crematory Inc. Baltimore, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. The matter of Months and Service Licensee

27. Name and Address of Facility

28. Name and Address of Facility

29. Frederick Road

29. Frederick Road

20. Battilling

23a. Part1. Enter the disease, or four plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21228 Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Myocardial Infarction Physician MIN /Medical Due to (or as a consequence of): Examiner Hypertensian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Probably 4 □Unknown 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Peripheral vascular 24a. Was an certificate has autopsy page performed Congestive 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Hospital: Other: 4 Nursing Home 5 A esidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bel Air , MO 2/0/4 30. Name and agrees of person who completed cause of death (Item 23a) (Type, Print) Charapeake Dr. Hyung 32. Registrar's Signature 31. Date filed (Month, Day, Year) WAY 1 8 2004 Registrar

Division of Vital Records, or Attending Physician: this After death. Director: after within 24 hours a To the P

Approximate Interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4-②Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\boxtimes$  Other (Specify) At SCENE Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 11:22 found investigation 1 ☐ Yes 2 X No Unknown 2 Accident Found: 4/1/2004 illed in by the 6 X Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)
 Comstack Road 4 Homicide Found in woods 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 2, 2004 30. Name and address of person who com of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) MAY 1 8 2004 32. Registrar's Signature State Registrar **ORIGINAL** 

Stuart Allen White Unpend Please Type or Print in Black Indelible 1/21/0 Ensure All Copies Are Legible. 04-03246 1- For Amend Item #11 per in 6831 5/18/04 tas Certificate of Death

State of Maryland / Department of Health and Mental Hygiene? 0 0 4

Certificate of Death

Red. No. RJ2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 13, Year 2004 **Physician** 0101 P.M STUART WHITE ALLEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2220 Penrose Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 1 M 2 □ F **Funeral** Days Hours Min. Year) Months 43 218-70-5733 AUGUST 3,1960 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show the Medical Examiner must be notified at XXYes 2 No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Itams 23a 2220 PENROSE AVENUE USA 21223 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, elc. hours after -+₩ Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☑ Divorced Year or Dates: BLACK "natural", 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than " than Elementary/Secondary (0-12) College (1-4or 5+) FULTON AUTO 11 AUTO DETAILER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MACIO WHITE INEZ HALL 2 traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau 2220 PENROSE AVE. BALTIMORE, MARYLAND 21223 INEZ WHITE/MOTHER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5-19-2004 MT ZION CEMETERY BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 mes Approximate Interval Between Onset and Death 23a. Part Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Heroin Intoxication Complicating Acute And Chronic Asthma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a o. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Cocaine Use Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No Attending Physician: diractor 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5% Residence 6 Other (Specify) 2 No Certification: To 1 ₹ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury Found 5/13/2004 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Division Foundhry 5 Pending 1 Natural 1 Yes 2 No death. investigation Unknown 2 ☐ Accident 12:50 after death Director: the 6 Could not be determined 3 ☐ Suicide Location (Street and Number of Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. in by 4 Homicide ö Residence Baltimore, Md within 24 hours a
To the Funeral E
completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and litle of certifier OCME May 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)111 Penn Street, Baltimore, Maryland 21201 RUBIO, MO ANA 31. Date filod (Month, Day, Year) 32. Registrar's Signature State books MAY 1 8 Registrar 2004

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		1 - For State Registrar		State of	Mary	land / Dep <i>Ce</i>	artmen <i>rtificate</i>			nd N	lental Hy	/gien Reg. N	0.0	07.	15010
Physicia	an	Decedent's Name (First, Mid     Darlene	die, Last	")	TA	lilson					2. Date of D	aath	ay	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institut 3236 Ravenwood				ilison			Location of	Death	May 1		2004 c. County	of Death	0544 P.M
Funeral Director		5. Social Security Number 216-74-4588	6. Se		7. Age (In	yrs. last birthday) Yrs.	If Under Months	Balt: 1 Year Days	More If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D	a <i>y, Y</i> ea	NA r)	9. Birthp Coun	
show		Usual Residence of Decedent  10a. State 10b. Coun	у			. City, Town or Lo	ocation					<u> </u>			Od. Inside City Limits
e or 28e-f show Lbe notified at	Director	Md. NA				Baltimo									1 Yes 2 □ No
23e or		3236 Ravenwoo	rA bo	7e.			10f. Zip	213				10g. C	itizen of V USA	What Coun	try?
0,1	by Funeral	11. Marital Status  1   Never Married 2 Ma 3   Widowed 4   Divorce	rried	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	ces? 2 No e X		Was Decede	ent of Hi ify Cuba	spanic Origi n, Mexican, Specify:	n? (Spe Puerto	ecify Yes or No Rican, etc.)	)- 	14. Rac	e - America ck, White, e	
then "netur	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	est grad	cation e <i>completed)</i> College (1	4or 5+)	(Give	dent's Usual kind of word DO NOT use	k done a	luring most o	of workii	ng	16b. i	Kind of Bu	usiness/Ind	
other t	Be Co	NA 17. Father's Name (First, Middle	, Last)			Une	mploy	red	18. Mother's	s Name	(First, Middle		NA n Sumam	re)	
marked	To E	Harry 19a. Informant's Name/Relation	ahia (Tu	una Deinel	W	est			Lau				inia		Wilson
n 27 is i		Laura V. Wilso		Mothe	r						Route Numb			State, Zip. 212	
i: If iten		20a. Method of Disposition 1   Burial 2 □ Cremation		lemoval from S		b. Place of Dispo cemetery, cren	sition (Name	e of			ate			City or Tov	
Departme fmporten any injury once.		4 □ Donation 5 □ Other ( 21. Signath e of Funeral Service		Zek	R		. Name and	Addres	s of Facility	-17	Bal	tim	ore,		, Md. 21202
		23a. Part1. Enter the disease, of shock, or heartfailure. Lis	r compli	cations that ca	used the d	eath. Do not ente	arcn or the mode	of dying	East , such as ca	ırdiac oı	1101 F	rest,	orth		Approximate Interval Between
sician ledical	I	Immediate Cause (Final disease or condition resulting in death)	a	LULTU Due to /o		sequence of):	HROM	BOE	MBOL	(S )	2				Onset and Death
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	al Examiner	Causa (Disease or injury that initiated events resulting in death) Last	C	Due to (c	r as a cons	sequence of):									
றைக்	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 50 Nknown	23	3c. If yes, outc 1 □ Live bir 4 □ Pregna 9 □ Unknov	th 2□F ntattime o	etal death 3	Ectopic pred Other (spec					Î	23d. Date Mon	of delivery	/ Vay Year
engi be q	à	Part II. Other significant condit	ons con	tributing to dea	ith but not	resulting in the un	derlying cau	ıse giver	n in Part I.				_		cause of death?
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this certal direct	0	25. Was case referred to medical examiner?  1XX Yes 2 □ No  27. Manner of Death  1 爲Natural 5 □ Pendi	He	28a. Date of		ER/Outpatient		Othor	4 Nursi	ng Hom	(Check only of e sid 3d. Describe h	ence			1,000
tor:	ertificat	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	gation not be nined	28e. Place o building	f Injury - Al g, etc. <i>(Spe</i>	t home, farm, stre	et, factory, o		es 2 □No	28	Bf. Location (S City or Tow	treet an n. State	d Number	r or Rural F	Route Number,
Funer ely fill		29a. Certifier 1 Certifyi (Check only 2 Medical	g Physi Examin	ician: To the b er: On the bas and manne	is of exami	nowledge, death ination and/or invi	occurred at estigation, in	the time	, date and p nion, death o	lace, ar	nd due to the c	ause(s) late and	and man place, ar	ner as stated	ed. ne cause(s)
To the complet		29b. Signature and title of certific	r	4				License I	number		4			(Month, Da	- 1
x		30. Name and address of person	who con	npleted cause	of death (It	em 23a) (Tvna P		CME 1 D-						2004	
State			NBI	10, H	and the same of th		11.	ı Pe	nn Sti	reet	, Balt	imoı	re, M	laryla	and 21201
Registrar	-31	MAY 1 8 21			ne		book	11							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician** 05 200 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE MANOR NURSING HIME 46166 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2×F North Carolina Director 214-22-8358 89 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "net-recorded to the formal pay of other formal pays." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ·MD Baltimore 1X Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 Rockrose Avenue 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: black Be Completed by 3 Midowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) fountain help pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bernice Rochester/niece 2930 Baker Street Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 🖺Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AtheroscleroTic Cardiovascular Discare

Due to (or as a consequence of):

Perpheral Vascular Desease **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Medical Certification: To Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 10 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospitel: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mennar of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1- Natural 5 Pending 1 Tyes 2 No death. investigetion 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 ŝ 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue 3400 Sabapalhi Kames 31. Dete filed (Month, Day, Year) MAY 1 8 2004 32. Registrar's Signalure State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

			For State Registrar	State of	Marylar	•	artmen rtificat			ınd Me	ntal Hyg	iene 19. No.	2001	+ 158	18
	Physici		1. Decedent's Name (First, Middle, Las Gladys B.		lliar						Date of Deat Month	h Day	Yeer 2004	3. Time of Deat	h M
>	/Medic Examir		4a. Fecility Name (If not institution, give Future Care Cherry		ber)				Location o	f Death		1	County of Dea Baltimo	th	
	Funeral Director		5. Social Security Number 6. Security Number 213–20–1614		7. Age ( <i>In yr</i> s. 88	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 8.	Date of Birth (Month, Day, cember		C	thplace (State or Fore ountry)  MD.	eign
	ter death with the Maryland Items 23s or 28e-f ehow est into the rediffed at	Director	Usuel Residence of Decedent  10a. State 10b. County  MD			ty.Town or Lo								10d. Inside City Lin	
	th with the		10e. Street and Number 6517 Parr Avenue				10f. Zip	Code 21215					zen of What Co ted Sta		
920	te o	by Funerai	11. Marital Status  1 Never Married 2 Married  3XXWidowed 4 Divorced	12. Was Deced Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2 ∐XNo e		Was Deced If Yes, spec 1  Yes	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		14. Race - Ame Black, Whit Specify: Wh	te, etc.	
1215-0	within ene. than	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-	4or 5+)	life.	dent's Usua kind of wo DO NOT us e Mak	rk done d se retired)	urina most	of working			nd of Business	/Industry	
aryland 2	be filed stal Hyg od othe event,	To Be Co	8th 17. Father's Name (First, Middle, Last)			Unknow	n		Ber	tha	Seis	Aaiden	Sumame)		
	7 - 7 - 3		19a. Informant's Name/Relationship (7 Vincent J. Merlo		Son	502	Berry	mans	Lane				Md. 2	,	
Baltimore,	0 0 = =		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		tate	Place of Dispo cemetery, crer odlawn				Date 5/17/0			cation - City or llawn ,	Town, State Maryland	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen.  23a. Part1. Enter the disease, or comp	se/		8:	2. Name an	iber	ty Ro	Lorin	andalls	stow		Directors	
>	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (c	de la	stall	ب (	0	0	rncei				Interval Between Onset and Death	
8760,	death certificate be executed the attending physicien and be for use as the burial-transit	ical Examiner	Seque maily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence as a consequence										
.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta int at time of c	al death 3□	Ectopic pr					2	3d. Date of del Month	ivery Day Year	
rds, P	The law requires that the tite has been signed by thoage 2 should be detache	þ	Part II. Other significant conditions of	entributing to de	ath but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob			the cause of death?	
Vital Records,		Completed									24a. Was an autopsy perform	/	24b. Were au prior to death?	utopsy findings availa completion of cause	ble of
Vita	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ № 6	Hospital:	patient 2	ER/Outpatien	nt 3 DC	Othe			Check only one	1	☐Other (Spe	-16.1	
ion of	ling After fune	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date o		28b. Time of Injury		28c. Injury Work		280	I. Describe ho			спу)	
Division	in Die	Certification;	3 Suicide 6 Could not be 4 Homicide determined	buildin	g, etc. ( <i>Specil</i>						City or Town	, State)		ural Route Number,	
	ne Hospitel n 24 hours a ne Funeral	edicai	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Examone)	rsicien: To the liner: On the ba and mann	sis of examina	owledge, death ation and/or in	n occurred vestigation	at the time, in my op	e, date and inion, deat	place, and h occurred	I due to the ca at the time, da	use(s) . ite and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complet	¥	29b. Signature and title of certifier  Chimiene X	hud	MD		290	c. License 54	number 0 2 C	ر	29	d. Date	signed (Monti	h, Day, Year)	
	6		30. Name and address of person who co	ompleted cause	A	n 23a) (Type, ろ り0	Print)	Sn.	tal	Jan 1	rve	8	rule à	215 GlenB	KIN
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 8 201	RI.	gistrar's Signa	ature	و معرو	**						026	161

		1 - For State Registrar AMEND IIEM #2		Maryland / Dep 831 5/26/04 <b>(Ite</b>				Reg. No. 20	04 15819
Phys	ician	Decedent's Name (First, Middle, La     Hilda M. Yor				·	2. Date of Dea	ath MAY 15,2	3. Time of Death
/Me	dical	mida M. ioi		ber)	4b. City, Town, o	or Location of	May Death	4c. County o	04 5:45 P M
LXai	illiei	Spa Creek				polis			Arundel
Funer Directo		304-28-0424	Sex 7 1 □ M 2 🔀 F	. Age (In yrs. last birthday, 73 Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Birt Min. (Month, Day July 3,	h y, Yeer) 1930	Birthplace (State or Foreigr Country)     Ohio
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Maryl I-f aho	ğ	Maryland Carro	11	Svl	kesville				1 ☐ Yes 🏋 No
ith the or 28s	Olrec	10e. Street and Number			10f. Zip Code	. =		10g. Citizen of Wh	•
ath wi	rai	1304 Terrace Cour				1784			States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Hem 27 is marked othar than "natural", or Itams 23a or 28a-f ahow any injury or othar traumatic event. In Medical Exam per must be mailfied at	by Funeral Director		12. Was Deced Armed Ford 1 Yes 2 If Yes, Give	2 ₹ No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origi an, Mexican, Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race Black Specify:	- American Indian, White, etc. White
5-00 72 hou nature	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup	during most (	of working	16b. Kind of Bus	iness/Industry
21215-0036 3d within 72 hours aff rgiene. ar than "natural", or it, the Wedical Exam.	amo	Elementary/Secondary (0-12)	College (1-4	for 5+)	DO NOT use retired LYESS	d)		Food Set	erri co
othar	Be Co	17. Father's Name (First, Middle, Last	)	Walt	1699	18. Mother	s Name (First, Middle,		
arylan, should be nd Mental marked o	To B	Okrey Richardson				Flora	E. McQuea:	ry	
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event		19a. Informant's Name/Relationship ( Rhonda Tanner – I			ng Address (Street Terrace		or Rural Route Number Sykesville		
Baltimore, Noemit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo		200	Date	20c. Location - C	
Itimor it. Pages rtment of I rtant: If Ite		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	(y)	Meadworid	dge Mem.		/19/04	Elkridge	e, Maryland
Balt permit. Departr Importa	500 0	N.Pd		Ga 72	ary L. Ka 250 Washii	ufman ngton	Funeral Hor Blvd. Elki	ne At MMI ridge, Ma	P., Inc. aryland 21075
<u> </u>		23a. Part <sup>1</sup> . Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on eac	ch line.					Approximate Interval Between Onset and Death
Physicia /Medica		disease or condition resulting in death)	aDue to (or	r as a consequence of):	inic (	m fi	cong up al	5	140
Examine		Sequentially list conditions,	b						
led sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequence of).					1
D, execut in and ial-tran	Examiner	that initiated events resulting in death) Last	C. Due to (or	r as a consequence of):					
8 760, sate be executed hysician and the burial-transit	Ilcal		_ d						
X 58 sertifica ding pt	/Med	IF FEMALE:	220 If you out on	nma of programmy	-200				
OT VITAL RECORDS, P.O. BOX 68/6U, Physicien: The law requires that the death certificate be executed rthis certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birt	nt at time of death 5	Ectopic pregnancy Other (specify)	′		23d. Date of Month	•
Cords, P.O.  wrequires that the de been signed by the s should be detached	by Pt	Part II. Other significant conditions	contributing to dea	th but not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
Ora require sen si							1 🗆 Y	es 2. <b>₫∰</b> o 3	☐ Probably 4 ☐ Unknown
f VITAI RECORGS, ysicien: The law requires to is certificate has been signe director, page 2 should be or	Completed						24a. Was a autops perform	sy prid med? dea	re autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
VICE icien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Other		f Death (Check only or		
OT Phys or this eral dii	7: 70	1 Yes 2 Ao 27. Manner of Death	28a. Date of (Month,		28c. Injun	y at	ing Home 5 Reside	ence 6 Other ow injury occurred	
VISION of Attending I death.  actor: After by the funer	atlor	1 → Hatural 5 Pending 2 Accident investigation	n	Day Year) Injury	Work	k? Yes 2 □ No	,		
DIVISION OT VITAI lal or Attending Physicien: 7 s after death. si Diractor: Atter this certifical ed in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Hornicide determined	289. Place of	f Injury - At home, farm, str , etc. <i>(Specify)</i>	eet, factory, office		28f. Location (St City or Town	treet and Number n, State)	or Rural Route Number,
UIVISION O  To the Hospital or Attending Ph with n 24 hours after death.  To the Funaral Director: After th completely filled in by the funeral	dical	29a. Certifier 1 Certifying Ph	nysician: To the b niner: On the bas and manne	est of my knowledge, deatl is of examination and/or in r stated.	vestigation, in my of	pinion, death	occurred at the time, d	ate and place, and	due to the cause(s)
To # with To # comp	Me /	29b. Signature and title of cartifier	pun	S	29c. License	DPJ 0	36 <sup>2</sup> e Uis Le	9d. Date signed (	Month, Day, Year)
\	0	30. N. e and address of person who	completed cause	of death (Item 23a) (Type,	Print) Junuh	10-10	e Chiste	~ M D	2/6/4
	tate	31. Date filed (Month, Day, Year)	El.	gistrar's Signature					
Regis	_	MAY 1 8 20	U4 Alle	we st for	West				

Ashley Blair Young unpend item#23a,27,28a-f,PER ME,C332,6/9/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03238 amend item#16a-b State of Maryland / Department of Health and Mental Hygiene cm 1 - For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 13 **Physician** 1:37 A<sup>M</sup> 2004 May **ASHLEY** BLAIR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2**XX**F Yrs. 20 Director 215-04-3477 09/27/1983 MARYLAND Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturat", or Items 23e or 28e-f show the Medical Examiner must be notified at GLEN BURNIE ANNE ARUNDEL MD 1 Yes 2 No Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21060 456 NOLHEIGHT ROAD Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 □Yes 2√XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXXNO Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STUDENI 12 NEVER WORKED of Health and Mental Hygid item 27 is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HILDA C. KNIGHT DENNIS E. YOUNG, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS E. YOUNG, SR. - FATHER PO BOX 1819 GLEN BURNIE, MARYLAND 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State GLEN HAVEN MEMORIAL PK. 5/15/2004 GLEN BURNIE, MARYLAND \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY 5., GLEN BURNIE, MD 21061 KELLY CRECORY FINK #M01148 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic Intoxication /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): certificate be executed that initiated events resulting in death) Last Exami Due to (or as a consequence of): Box 68760. physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Hospitel or Attending Physician: The law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 WUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? 1 Xyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XEP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1X Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural found 5/13/04 found 1:13a 1 Yes 2 No unknown 2 Accident Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide found in a car 7242 Montgomnery Rd., Elkridge, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated

24 hours a Funeral I within 24 the

> 111 Penn Street, Baltimore, Maryland 21201 THESDORE Miker MAY 1 8 2004 🖈 32. Registrar's Signature Sparke

30. Name and address of person who completed c - of death (Item 3a) (Type, Print)

29b. Signature and title of certifier

State Registrar 29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 13, 2004

			For State Registrar		nd / Departme	ent of Health and ate of Death	Mental Hygi		14 1582
			Negistrar     Name (First, Middle, L.	_ast)			2. Date of Death	g. 110.	3. Time of Death
	Physici		2270403	P. ZinKAR	$\sim$		Month 5	Day Year	4 04:55 PM
7	/Medic Examir	3	4e. Facility Name (If not institution, g			ity, Town, or Location of Deat		4c. County of Dec	*
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	Funeral			. Sex 7. Age (In yrs.	last birthday) If Un Monti	der 1 Year   If Under 24 Hrs		9. Bi	rthplece (State or Foreign country)
	Director		217 26 6177	1 M 2/8 F	Yrs.	ns Days Hours Min.			RYLAND
	pu ,		Usuel Residence of Decedent  10a, State 10b, County	10c Ci	ity, Town or Location	,	3		10d. Inside City Limits
	show	_	10a. State 10b. County	100. 01	ity, Town or Location				1 ☐ Yes 2X No
	Ba-f	cto	LYBATAIO RUTI	more	rerry H	ALL			
	vith th	Director	10e. Street and Number		• 10f.	Zip Code	10	g. Citizen of What C	ountry?
	s 23e	ral	4501 A. 1ALL		10 10 10 10	21128	>#: V M-	14. Race - Am	nion Indian
	tham tham	Funeral	11. Marital Status  1 ☐ Never Married   2   Marned	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	If Yes, s	scedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Wh	
36	hours after death with the Maryland tural', or flams 23a or 28a-f show at Exer'in er mart be redified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Ye	s 25 No Specify:		Specify	17.14
Ş	n 72 hours after death with the Marylan "natural", or Itams 23a or 28a-f show isolical Exertinat be profified at	ed	15. Decedent's	Education	16a. Decedent's U	Isual Occupation	. 10	Sb. Kind of Business	s/Industry
15	in 72 . n nat	Completed	(Specify only highest g Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give kind of life. DO NO	work done during most of wo Tuse retired)	rking		
21	d within giene. Ir than	mo	127R5	3785-	12.1		1	IIRCY H	LATIAZO
Þ	be filed withintal Hygiene. Id other then	BeC	17. Father's Name (First, Middle, Las	st)		18. Mother's Na	me (First, Middle, M.	aiden Sumame)	
<u>a</u>	D 8 2 0	To	JOHN N.	BRENNAG		ADDE	TOK	ARI	
Maryland 21215-0036	d 2 should the and Men 7 is marke traumatic	0 =	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ess (Street and Number or R	ural Route Number	City or Town, State,	Zip Code) 21128
	and seatth m 27 her tr	8	Andrew J- Lin	KAND, SR.	H501H-	31 Trollai	RRACEL	ERRYHAU	1 JARYLAND
Baltimore,	- I 0 -		20a. Method of Disposition  Salarial 2 ☐ Cremation 3		Place of Disposition (cometery, crematory)	Name of or other place)	Date 20	oc. Location - City o	r Town, State
Ĕ	nit. Pages vartment of ortant: If it injury or o		'4 □ Donation 5 □ Other (Spec		RKWOODL	of batterns	DO4 1	ARKVILLE	Challagill
a	permit. Pag Department Important: any injury o		21. Signal The Strong Lic	ense	22. Name	and Address of Facility	CECORI	22 0	31128
<u>m</u>	897 29		Leaf Vin	64	088	HARFORD R	040 PARK	1 / sillive	ONALYS
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the deally one cause on each line.	th. Do not enter the n	node of dying, such as cardia	c or respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sepsi					Onset and Death
al.	/Medical		resulting in death)	Due to (or as a consec	quence of):				
20.	Examiner		Sequentially list conditions,	pheun	pinon				
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Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Feta	al death 3 ⊟Ectopi	c pregnancy		23d. Date of de Month	olivery Day Year
	the de by the a tached f	/sic	1 ☐ Yes 2 M No 9 ☐ Unknown	4⊡Pregnant at time of o 9⊡ Unknown	death 5 Cher	(specify)			
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ds,	w requires that been signed I should be det	1 by	Clostvidia		e Ca	litic	1 ☐ Yes		robably 4 Unknown
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žec	The law cate has I	Completed by					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital Records,	ician: Th certificate rector, pag						1 Yes 20	▼ No 1 □ Ye	s 2 No
V:	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	3-00	Other	ath (Check only one,		
ō	Phys r this ral di	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Minpatient 2 L	ER/Outpatient 3 28b. Time of	DOA 4 Nursing H	fome 5 ☐ Residen		ecify)
D	ding I h. After funer	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	Injury	Work? 1 ☐ Yes 2 ☐ No		,,	
S	deat deat ctor: y the	fica	3 Suicide 6 Could not	be 390 Blace of Injury At h			28f. Location (Stre	et and Number or R	tural Route Number.
Division	l or Attandi after death. Director: A i in by the fe	Certification:	4 ☐ Homicide determine	building, etc. (Speci	ify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town,		
_	To the Hospitel or Attanding Physician: The law requires that the death certifical within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying I	Physicien: To the best of my known	owledge, death occur	red at the time, date and place	e, and due to the cau	se(s) and manner a	s stated.
	24 h 24 h Fui	Medical	(Check only 2 Medical Ex one)	aminer: On the basis of examina and manner stated.	ation and/or investigat	ion, in my opinion, death occu	urred at the time, dat	e and place, and du	e to the cause(s)
	fo th within Fo th	Me	29b. Signature and title of certifier	1 11.		29c. License number		d. Date signed (Mon	
	- > - 0		N. Meje	evoi, Mr	2	RES OOC	) (	15/15/	2004
	11			<u> </u>	m 23a) (Type, Print)				
	10		Nicdai Meie	voi, 5601 La	och, Ray	en Blud. E	Saltim	ove, M	0 21239
1	Sta	ate	30. Name and address of person whe Nicola', Me'se and address of person when the Nicola's Mary, Years and MAN Day, Years and Nicola's Man Day,	NA 35 Begista Sign	ature 1	alla!			
45	Regist	rar	MHI TO 20	UT /	/ //	4.30			

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:25007 Mary Elizabeth Zumstein 4b. City, Town, or Locetion of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death N/A Roland Park Place Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Oct. 7, 1913 1 □ M 2XXF Months 214-40-4081 90 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Baltimore** Maryland N/A 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 830 W. 40th St. United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Kantner William Zumstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2198 Stone Rd. Westminster, MD 21158 Elizabeth Cree/cousin 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/21/04 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 21. Signature of Funeral Service Licensee John Jutabel 6500 York Rd. Baltimore, MD incl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, lock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the ceuse of death? 1 ☐ Yea 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Chrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 13/10 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examiner

Examiner

Physician/Medical

ģ

Completed

Certification: To Be

Medical

1 Watural

2 Accident

4 ☐ Homicide

(Check only one)

3 Suicide

29a. Certifier

5 Pending investigation

6 Could not be determined

**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

Completed by

Be

Funeral

Director

filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mantal Hygiene. Important: If item 27 is merked other than "neturel", or items 23e or 28e-f show entry injury or other treumatic event, the Medical Examiner mast be notified at once.

ata hes been signed by the attending physician and page 2 should be detached for usa as the buriel-transit To the Hospital or Attending Physicien: The law requires that the death certificate be axecuted

ours efter death.

erei Director: Attar this cartifica

Division of Vital Records, P.O. Box 68760,

0

within 24 hours e To the Funerei C complataly fillad

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7. IS ABILIE THE RELAR, \$30 W. 40 H. Street, Baltenure, Ted 21211

31. Date filed (Month. Dav. Year) 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

8 2004

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Yeer)

	nd Items 10e,19a,b per in,631,0	yland / Department of Healt Certificate of Dea	th and Mental Hygiene	004 15823
Physician	cedent's Neme (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
/Medical Examiner	ANCY CZAB acility Name (If not institution, give street and number)	4b. City		2004 5 - 50 A P
Examine	GHTWOOD MERIDAN NURSING C	NTFR	HERVILLE BALT	IMORE
Funeral Director	cial Security Number 6. Sex 7. Age (	In yrs. last birthday) If Under 1 Year If Un Months Days Hou	der 24 Hrs. 8. Date of Birth (Month, Dey, Year) 10/03/1946	Birthplace (State or Foreign Country)     GERMANY
yland sow		Oc. City, Town or Location		10d. Inside City Limits
Ba-f st	D BALTIMORE	BALTIMORE		1 ☐ Yes 2 ☐ No
iter death with the Ma riterns 23s or 28s-1s iner must be notified Furneral Director	Street end Number Jones Falls Terrace JONES VALLEY TERRACE	10f. Zip Code 21209	U.S.A	What Country?
	Iarital Status  ☐ Never Married 2 M Married ☐ Widowed 4 ☐ Divorced  12. Was Decedent Event Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U,S.  13. Was Decedent of Hispanic If Yes, specify Cuban, Mex  1  Yes  Y No Specify No	ricen, Puerto Rican, etc.) Bia	ice - American Indian, ack, White, etc. ify: WHITE
nd 21215-0020 De filed within 72 hours aff ital Hygiene. I other then "natural", or event, the Medical Exern Re Completed by B	15. Decedent's Education (Specify only highest grede completed) ementary/Secondary (0-12)  College (1-4or 5+) 5+	16a. Decedent's Usuel Occupation (Give kind of work done during i life. DO NOT use retired)	most of working	Business/Industry
filed v Hygie Other t	ather's Neme (First, Middle, Lest)	SOCIAL WORKER	Other's Name (First, Middle, Meiden Surna	me)
Maryland nd 2 should be file lith and Mental Hy 27 is marked oths r treumatic event, To Be C	СОВ	ZABA DO		ROBOTNIK
Mar nd 2 sho lith and 17 is m	Informent's Name/Relationship (Type, Print)  MES DAME / HUSBAND	19b Mailing Address (Street and Nu 9 Jones Falls Lerrac 9 JONES VALLEY T	ımber or Rural Route Number, City or Towr ≊ Terrace ERRAÇE BALTIMORE, Mi	n, Stete, Zip Code)
Baltimore, semit. Pages 1 ar Department of Hear moortant: if item 2 my injury or other note.	Mothed of Disposition	20b. Place of Disposition (Neme of cemetery crematory or other place) BETH TFILOH CEMETERY	Date 20c. Location	- City or Town, Stete
Balti pemit. Depertu importa any inju	Signatura of Funeral Service Licensee	22. Name and Address of Fa	acility SOL LEVINSON & BI TOWN RD. PIKESVILLE	
	Part / Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physician /Medical Examiner	ung in death)	ASTATIC BRE	AST CARCIN	
cuted and ransit	pentially list conditions.	e to (or as a consequence of):		
68760, tificate be executed g physician and es the buriel-fransit	uentially list conditions, y, leading to immediate e. Enter Underlying se (Disease or injury nitieted events ting in death) Last	e to (or as a consequence of):		
Box 68 auth certifice ettending pt for use es t	d			
P.O. Box net the death cent d by the ettending etteched for use PhysiclanM	I. Other eignificent conditions contributing to death but r	not resulting in the underlying cause given in P	ert I. 23b. Did tobecco use co	ontribute to the cause of death?
es that the de gened by the contract of the co			1 ☐ Yes 2 ☐ No	3 Probably 4 Uniknown
Vision of Vital Records, P.O. Box (Atending Physician: The law requires that the death certificated.  Attending Physician: The law requires that the death certificated.  Attention: After this certificate has been signed by the ettending by the funeral director, page 2 should be detected for use a fification: To Be Completed by Physician/M.			24a. Was an autopsy performed?	24b. Were eutopsy findings evailable prior to completion of cause of death?
of Vital Recoystian: The law nis certificate hes I director, page 2			1 □ Yes 2 □ No	1 ☐ Yes 2 ☐ No
Vita	Vas case referred to medical xaminer?		lace of Death (Check only one)	
g Physic er this conseral dire	Inpatient 28a. Date of Injury	28b. Time of 28c. Injury et	Nursing Home 5 Residence 6 Ott	
Division of Vital Records, To the Hospital or Attending Physician: The law requires th within 24 hours effer death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	Accident investigation	M 1 ☐ Yes 2	2 No 28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
Hospitai 24 hours - 5 Funerai   etely filled		ny knowledge, death occurred at the time, date amination and/or investigation, in my opinion, d.		
To the within To the compl	Signeture and title of certifier	29c. License numb	per 29d. Date sign	ed (Month, Dey, Year)
,	Sjuple MD	P0053	3150 MAY	130n 2004
9	ame and eddress of person who completed cause of dear	h (Item 23a) (Type, Print)	303 Ellings	(174 3,043
State	Pate filed (Month, Day, Year) 32. Registrer's	Signature	death occurred at the time, date and place, over 29d. Date sign.  3 150 MAY	-19 21012
Registrar	MAY 1 8 2004 Server	sparker		

			For State Registrar	State of N	Maryland		artment rtificate			and Me		giene. Reg. No.!	Z 11 11 L	15	824
	Physici	an	Decedent's Name (First, Middle, Last)     Date of Death									ath Day	Year		of Death
	/Medic	al	Richard Sothern Anderson  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								May	3	200 County of De		O P M
	Exami	ie:	Frederick Memorial Hospital Frederick								Frederick				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show 50 and any injury or other traumetic event, it we Medical Exercit set must be notified at once.		,	Sex 7. / 1 □ M 2 □ F	Age (In yrs. las 81	t birthday) Yrs.	If Under 1 Months	1 Year Days	If Under : Hours		8. Date of Birtl (Month, Day March 2	h Y Year)	9. B	rthplace (State country) yland	e or Foreign
			Usual Residence of Decedent				1				Taren 2	,	/25   IIa I		
		ō	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$												
		Director	10e. Street and Number 10f. Zip Code									10g. Citiz	zen of What C		Λ
		ralD	6509 Springwater Court 21701								USA				
36		by Funeral	11. Marital Status  1 □ Never Married 2 ☆ Married  3 □ Widowed 4 □ Divorced	nt Everin U.S. s? ⊒No s: WW II	If Yes, specify Cuban, Mexican, Puerto Rican, e						r No- ) 14. Race - American Indian, Black, White, etc. Specity: White				
Maryland 21215-0036		Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working						16b. Kind of Business/Industry						
7		omp	Elementary/Secondary (0-12) College (1-4or 5+)  12 Supervisor							Auto Sales					
p		Be	17. Father's Name (First, Middle, Last								(First, Middle,	Maiden	Sumame)		
<u> </u>		L C	Richard S.  19a. Informant's Name/Relationship	Anderson		10h Mailir	a Addross	(Stroot 2		va v or Bural	Estel Route Numbe		Roth		
<b>∑</b>			Lucille Anderson								Frede				
ore,			20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from Sta		e of Disponence	sition (Nam natory or oth	e of her place	g)	Da	ite	20c. Lo	cation - City o	r Town, State	
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	fy)	Fred	-	Crem				2004		derick		
Ba			21. Signatur of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Home, PA  1621 Opossumtown Pike Frederick, MD 21702												
	ysician: The law requires that the death certificate be executed with the attending physician and use igned by the attending physician and director, page 2 should be detached for use as the burial-transit	1	23a Párt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Open and Doubt												
			disease or condition  disease or condition  a. Congestive heast four years  1 Day												
ı			Sequentially list conditions,	Due to (or as a donsequence of):  b										/	
		Examiner	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
oʻ		Exar	that initiated events resulting in death) Last												
8760,		dical	d												
O. Box 6		by Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery  Month Day Year			Year	
o. G			Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?				f death?
ord		ted	Coronary	arte	y F	32.1C	201	<u>e</u>			1 🗆 Y	1 ☐ Yes 2 No 3 ☐ Probably 4			Unknown
I Record		Completed	- Diabetes Hypertens	Hupertension							performed? death?			completion of	
Viita		Be	25. Wa a r ferred to medical axaminer? 26. Place of Death (Check only one)												
٥٥	ig Phys ter this neral di	n: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1 Inpatient   2   ER/Outpatient   3   DOA   0   0   0   0   0   0   0   0   0											
Division of	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	icatic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	ion M 1 Yes 2 No											
Ω		Certification:	4 ☐ Homicide determined							28	281. Location (Street and Number or Rural Route Number, City or Town, State)				
		edical	29a. Certifier (Check optione)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To t Withi To tl	×	29b. Signature and title of certifier				29c.	License	number	2	2	9d. Date	signed (Mon	th, Day, Year)	
	-		30. Name and address of person who	Ohah completed cause o	f death (Item 2)	<b>n ∫</b> ∩ (Type,		T)	164	7		7	1104		
	2		65 C Tho	mas,	Thon	SOV	Dr	5	Fre	der	ick	ms	F16 (	02	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4 April 100 April 10															

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 15825
	¥		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physicia		Eleanor Mae Benchoff  Eleanor Mae Benchoff  Month  Tolay  Year  1027 PM
Tr.	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examin	er	Washington County Hospital Hagerstown Washington
	Funeral		5. South Description Name of Birth 9. Birthplace (State or Foreign
н	Funeral Director		202-20-5263 1 M 2 F 76 Yrs. Months Days Hours Min. (Month, Day, Year) Country)  Teb 1, 1928 Waynesboro, PA
			Usual Residence of Decedent
	how		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	e-fs	cto	PA franklin Waynesboro
	ih th or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	23e	ai	302 Geiser AVE 17268 USA
	r deas	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
36	or It	<b>by</b> Fu	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Specify Specify No Specify:
00	hin 72 hours after death with the Maryland an "natural", or Items 23e or 28e-f show Medical Examirat must be rediffed at		3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education   16a. Decedent's Usual Occupation   16b. Kind of Business/Industry
5	"nat	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
12	is die	шc	Elementary/Secondary (0-12) College (1-4or 5+)  12 Clerk Department Store
0	filed Hygi thar Int.	ပိ	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
an	0 ta D 9	To B	John W. Minnich Earla M. Muth
Maryland 21215-0036	d 2 should be th and Menta 7 is marked traumatic e	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	nd 2 alth a 27 is		Paul G. Benchoff husband 302 Geiser Ave. Waynesboro, PA 17268
Baltimore,	f Healt Itam 2 other		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Ë	0 5 = 5		1½ Burial 2 ☐ Cremation 3 ☑ Removal from State 3 ☐ Creen Hill Cemetery May 12, 2004 Waynesboro, PA 17268
Ħ	그는 무 판 근		21. Signature of Funeral Service Licensee 122. Name and Address of Facility Grove-Bowersox Funeral Home, Inc.
ñ	Depar Impor any ir		50 S. Broad ST Waynesboro, PA 17268
	94.		23a. Part I finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate Interval Between
	- Pnysician		Unset and Death
	/Medical		disease or condition resulting in death)  a
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a
	P ==	ner	if any, leading to immediate Due to (or as a consequence of):
)	cuted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.
<b>3</b> 6,	te be executed ysician and ne burial-transit		resulting in death) Last  Due to (or as a consequence of):
87 <b>6</b> 6	# × #	licai	d
68 3	ing p	Med	IF FEMALE:
Box	leath certificate b attending physic I for use as the b	lan/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy  23d. Date of delivery
0.	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it	Physician/M	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)
P.(	that the		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Records,	uires t signe Id be o	by	right intraparenchymal Bleed - Transactic 10 Yes 2 1 No 3 probably 4 Unknown
0	w requ been should	Completed	
3ec	The law cate has b	mpi	24a. Was an autopsy findings available autopsy performed?
al F			1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical symmetry (Check only one)  15. Vos 20 No. 4. Characterist 20 EB/Outpetient
of	Phys this	-T	Hospital: 1 ⊠ yes 2 □ No  Hospital: 1 ⊠ npatient 2 □ ER/Outpatient 3 □ DOA  Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)  27. Manner of Death  28a. Date of Injury  28b. Time of 28c. Injury at 28d. Describe how injury occurred
	ding F h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?
S	death death ctor: / the	ica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Division	lor A after Dira	Certification;	4 Homicide determined building, etc. (Specify)  Howard 1206 Face of Home, family, street, factory, office building, etc. (Specify)  10.2 92 1372 1808
_	spita ours naral fillec		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To th withir. To th sompl	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			Clar Play 8, 2004
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
			Edwardw. Ditto at, MD 19,011 Unchun & tenor Bd- 21742
	Sta		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eduar & W. Ditto at., (N. 19. 4.1) Uncleve & tence & Bd - 21742  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 1 8 2004  MAY 1 8 2004
	Regist	rar	MAY 1 8 2004 Sentire & Sparks
DH	IMH 17 Rev 1/2	2001	, , ,

ORIGINAL

·	1	State of Maryland / Departmen	t of Health and e of Death		21111	1. 15026
		1. Decedent's Name (First, Middle, Last)	e or Death	2. Date of Deat	eg. No.	3. Time of Death
Physiciar /Medica	۱.	BARRY LYLE BOOTH		Month MMY	Day 200 Year	1318 M
Examine			Town, or Location of Dea	ith	4c. County of Dee	
		Joseph Land Spirita	low ton		Prince	6 eoges
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under $219-56-1880$ 1 $\mathbb{R}^{M}$ 2 $\mathbb{R}^{J}$ 7. Age (In yrs. last birthday) Months $219-56-1880$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 1 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 3 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 3 $\mathbb{R}^{J}$ 2 $\mathbb{R}^{J}$ 3 $\mathbb{R}^{J}$ 4 $\mathbb{R}^{J}$ 3 $\mathbb{R}^{J}$ 4 $\mathbb{R}^{J}$ 3 $\mathbb{R}^{J}$ 4 $\mathbb{R}^{J}$ 5 $\mathbb{R}^{J}$ 4 $\mathbb{R}^{J}$ 5 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^{J}$ 6 $\mathbb{R}^$	1 Year If Under 24 Hr Days Hours Mir		Year) C	thplace (State or Foreign ountry) SH., D.C.
D	-	Usual Residence of Decedent		110100	1331 1111	OH . / D . C .
arylan		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
with the Ma	2		RANDYWINE			1 ☐ Yes 2 No
with th	5	106. Street and Number 107. Zip 107. Zip 108. Street and Number 14803 BADEN WESTWOOD ROAD		1	0g. Citizen of What Co	-
eath	2		20613	Specify Yes or No-	U.S.A	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ita Modical Examinat must be notified at once.  To Be Completed by Europe in Disorder	nn Lau	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give 1 Yes 1 1 Yes 1	dent of Hispanic Origin? ( cify Cuban, Mexican, Pue 2 XNo Specify:	rto Rican, etc.)	Black, Whi	te, etc.
21215-0036 d within 72 hours af giene. Then "netural; or the Midleal Exam!	20	15. Decedent's Education 16a, Decedent's Usua	al Occupation		16b. Kind of Business	/Industry
21215-00 led within 72 hou ygiene. ner than "natura	2	(Specify only highest grade completed) (Give kind of wo. life. DO NOT us	rk done during most of wase retired)	orking		
Market Parket	12 SERVIC				DISTRIBUT	
ind tal Hi doth even	מ	17. Father's Name (First, Middle, Last)		ame (First, Middle, A	,	
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	2	RAYMOND L. BOOTH			UDE SCHI	
Mal d 2 st d 2 st th and 7 1s r traur			(Street and Number or F			
Te, N 1 and Health tam 27 other tr	/-	20a. Method of Disposition 20b. Place of Disposition (Nan		Date :	BRANDYW, 20c. Location - City or	INE, MD. Town, Stete 20613
Pages nent of int: If it		1 ♥ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  T • PAUL S CEN	' ' 1		BADEN, MAI	
Baltimore, permit. Pages 1 as permit. Pages 1 as important: If item any injury or othe	1	21. Signature of Funeral Service Licensee MOO479 22. Name an	d Address of Facility			KILAND
20539	1	LA PI	<u>JATA, MARYI</u>	AND 2064	46	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	. 0		est,	Approximate Interval Between Onset and Death
Physician /Medical		resulting in death)	de Pois	min		
Examiner	1	Due to (or as a consequence of):		0.		
48 A	<u> </u>	Sequentially list conditions, if any, leading to immediate . Due to (or as a consequence of).				
executed in and ial-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
cate be executed by yield and the burial-transit	Ž	resulting in death) Last Due to (or as a consequence of):				
cate be ephysician the buria	2	d				
death certific death certific e attending p of for use as	DIA C	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	là can .
hat the death cer ed by the attendin detached for use	3	23b. Was decedent pregnant in the past 12 months?  1			Month	Day Year
Dy the achec	2	9 ☐ Unknown				
Records, P.O. Box 6 The law requires that the death certif the has been signed by the attending bage 2 should be detached for use as	2	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
				1 ☐ Ye	s 2,⊠No 3∏Pr	obably 4 Unknown
The law requires to take has been signed page 2 should be completed by	1			24a. Was ar autopsy	prior to	utopsy findings available completion of cause of
	5			perform 1 Yes 2	ned? death? □No 1 □ Yes	2 No
of Vital F Physician: Th This certificate ral director, pag	2	25. Was case referred to medical examiper?  Hospital:	Other	ath (Check only one		
O E E =		I inpatient 2 EH/Outpatient 3 DO	8c. Injury at		nce 6 Other (Spe w injury occurred /	
On O On O ding Ph		1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M. & 206 12 11 M	Work? 1 □ Yes 2 ☑ No	TO CAN	exposed 7	ocked o
DIVISION Of to Attending Phy after death. Director: After this in by the funeral death or the funeral deathfication: To	2	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory	, office		יאל אל אל אל אלי אלי אלי אלי אלי אלי אלי	
DIVISION ( Ital or Attending P Ital or Attending P al Director: After ed in by the funera		4 Homicide building, etc. (Specify)			16	one
Division To the Hospital or Attentivition 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	at the time, date and plac in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as	stated.
To the To the To the comple	2	29b. Signature and title of certifier 29c	. License number	29	d. Date signed (Mont	h, Day, Year)
		Salado Aleton 20	H00558	2-7	Mestry 7, 2	004
1171		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Drive Ch	one !	proses (a.	-0
State		31. Date filed (Month, Day, Year)  32. Registrar's Signature	-	91	-12/1-00	1
Registrar		MAY 1 8 2004 Denue &	hones !			

	,		1 - For State Registrar	State o	of Marylar		artment of H tificate of I		nd M	ental F	lygie Reg.		04	15	827
	Dhusisi		1. Decedent's Name (First, Middle, L	ast)						2. Date of Month	Death	Day	Year	3. Time of	f Death
	Physici /Medio		Ann	ie May 1	Beck					May			004	0635	$A^{M}$
	Examir		4a. Facility Name (If not institution, ga	ve street and nu	ımbər)		4b. City, Town, or	Location of	Death	_		4c. County	of Death		
			SunBridge Care				Elkton					Cec	il		
	Funeral			Sex 1 □ M 2 🗓 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min.	<ol><li>Date of (Month,</li></ol>	Birth Day, Ye	ear)	Cou	place (State ontry)	or Foreign
	Director		228-07-0582		86	Yrs.				MAR ]	1,	1918	Vir	ginia	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	ity Limits
	danyt f sho	៦	Marriand Cogil										ŀ		2 🗆 No
	28e-	Directo	Maryland Cecil  10e. Street and Number		E. J	lkton	10f. Zip Code				100	Citizen of V	Vhat Cou	otn/2	
	with Ba or		l Price Drive				21921				109			•	
	ns 23	era	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13. V	Was Decedent of Hi	ispanic Origi	in? (Spec	cify Yes or	No-	United		can Indian,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is markad other then "neturel", or Items 23a or 28e-f show aumatic event, the Madical Evandarian must be mailfied at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 X No ive	'	f Yes, specify Cuba 1 □ Yes 2🗓 No	n, Mexican, Specify:	Puèrto F	Rican, etc.)			k, White,		
ğ	2 hou	ted	15. Decedent's I				ient's Usual Occupa				161	o. Kind of Bu			
75	Madi	Completed	(Specify only highest g	a <i>de completed)</i> College (		(Give	kind of work done o DO NOT use retired	during most ( )	of workin	g				•	
7	d with	E O	8	College (	1 401 547	She	er Opera	tor			F	iber 1	Prod	uction	
פ	al Hygie other	Bec	17. Father's Name (First, Middle, Las	t)				18. Mother	's Name	(First, Mide	dle, Mai	den Sumam	ө)		
a	ould be Mental arkad o	ToE	John Henry Sarv	er				Mauc	de Ir	cene l	Neel				
ary	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Co									ity or Town,	State, Zip	Code)			
Σ	and 2 paith a 27 I		John W. Beck/So	n		134 (	Greenwood	Stree	et, E	Elkto	a, M	aryla	nd 2.	1921	
ore.	of He roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Domoval from	20b. F	Place of Dispo	sition (Name of natory or other place 15 & CO	e) [V	lay S	ate	1	Location -			
Ĕ	Pag nent ant: b		`4 □Donation 5 □ Other (Spec	ify)	Ind		ris & Co.	,	2004	,		est Che ennsylv			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic a DDGs.		21. Signature of Juneral Service Lice	7	1	22 Hj	Name and Address CKS HOME	s of Facility	uner	als,		_			
	All I		23a. Part1. Errer the disease, or cor shock, of heart failure. List ont	nolications that	caused the deat	th. Do not ent	03 W. Stoo	ckton	St.,	Elk1	con,	MD 2	2192	Approximat	Α
	Physician /Medical		shock, of heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to	each line.	bstruc	Tive Pru	lmono	ory	Dise	cuse			Interval Bett Onset and I	ween Death
	Examiner				mante	A			V				1	enhone	
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):								130/00	Wy
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0											
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9	tifica ng ph as th	led													
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 PNo 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)  Month										•	/ear	
<b>.</b>	w requires that been signed b should be deta	y P	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the ur	nderlying cause give	en in Part I.		23e. Di	d tobac	co use contri	bute to ti	ne cause of d	leath?
g	quires n sign	d by								1[	∃Yes	2 🗆 No	3 🗌 Prot	ably 4 🗹	Inknown
Vital Records,		Completed								24a. Wau pe	topsy rformed	?   de	Vere auto rior to co eath? ☐ Yes	psy findings ampletion of ca	available ause of
Ita	ilcien: The certificate hi rector, page	Be (	25. Was case referred to medical examiner?					26. Place o	of Death	(Check onl	y one)				
	Physic this ca	ျှ	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien		4 Privurs	ing Hom	e 5□Re	sidence	e 6 □Othe	r (Specif	v)	_
Division of	Attending P death. ctor: After t y the funera	atlon;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		of Injury hth, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at :? ∕es 2 ⊡No		3d. Describ	e how i	njury occurre	ed		
Divis	el or Attenes s after death Il Director: od in by the	Certification:	3 Suicide 6 Could not determined	280. Place	e of Injury - At hing, etc. (Specil	ome, farm, stre	eet, factory, office		28	Bf. Location City or 7	(Street Town, St	t and Numbe tate)	r or Rura	l Route Numi	ber,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and inion, death	place, ar occurred	nd due to the d at the tim	ne cause e, date	e(s) and mar and place, a	ner as si nd due to	ated. the cause(s)	)
	To t with To t	Σ	29b. Signature and title objectifier	Port N	w		29c. License	number 3322	2_		29d.	Date signed 5.	(Month,	Day, Year)	
	7		30. Name and address of person who	completed caus	se of death (Men	n 23a) (Type,	Frint) Suite	3B	, E	ek ?	n	5. ND 2	219:	2/	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 20	6	Registrar's Signa	ature	for w	4 7						•	
			m-A-	. /		15	MAKE THE STATE								

		1 - State Registrar	State of Marylar	nd / Depa		t of H	ealth a	and Mer	ntal Hyg	eg. No. 2	004	1582	
Physic		Decedent's Name (First, Middle, Last)  LOUISE	L.		BARTO	N			Date of Dea Month		04 <sup>Year</sup>	1:15 PMM	
/Medi Exami		4a. Facility Name (If not institution, give stre			4b. City, Town, or Location of Death						ty of Death		
	\$	2815 STARR ROAD					ANNE			QUE	QUEEN ANNE		
Funeral Director		5. Social Security Number 220-32-2122  Usual Residence of Decedent	<sup>7</sup> . Age (In yrs. <b>69</b>	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min	Date of Birth (Month, Day C. 11	1934	9. Birth Cou MAR	place (State or Foreign ntry) YLAND	
e Maryland le-f ehow	ctor	10a. State 10b. County  MD QUEEN ANNE		ity, Town or Lo					10d. Inside City Lim 1 ☐ Yes 2 X I				
with th	Director	10e. Street and Number			10f. Zip				1	10g. Citizen of What Country?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral	2815 STARR ROAD  11. Marital Status  1 □ Never Married 2 ★ Married	Was Decedent Ever in L Armed Forces? 1 Yes 2 ANo If Yes, Give	ł	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Ві	ace - Ameri ack, White	etc.	
d 2 should be filed within 72 hours af the and Mental Hygiene.  27 Is marked other than "natural", or treumatic event, the Medical Exam.	leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat (Specify only highest grade c	Year or Dates:	16a. Dece	dent's Usua	l Occupa	urina most	of working		Spec 16b. Kind of	MIT	ITE industry	
ed within ygiene. ner than it, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) -0-		DO NOT us				OWN HOME				
ould be fill Mental H erked otl	To Be	THOMAS ROE LEAVERTON  18. Mother's Name (Friest, Middle, Maiden Sumame)  VIRGINIA BENTON											
and 2 sho salth and n 27 Is m er treum	19a. Informant's Name/Relationship (Type, Print)  J. ROBERT BARTON/ HUSBAND  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z. 2815 STARR ROAD, QUEEN ANNE, MD. 21657										o Code)		
permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition  1	aval from Ctata	Place of Dispo cemetery, crei ENMOUN	T CEM	her place ETER	Y 5	Date 5-7-200	)4	20c. Location	ORO,	MD	
Departiment Departiment Importing		21. Signature of Funeral Service Library  MINISTRUCTURE 115 INSTRUCTURE 115 IN	Senlen	FE 40	LLOWS 8 S.	Addres HEL LIBE	s of Facility FENBE RTY S	IN & N	NEWNAM ENTREV	FUNER	AL HO MD 21	ME, P.A. 617	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	est, We		Approximate Internal Between Onsel and Death —								
te be executed ysician and te burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec										
eath certificat attending phy		IF FEMALE: 23c	If yes, outcome of pregn	ancy						2010			
The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1											
w requires that been signed t	b	Part II. Other significant conditions contri	outing to death but not res	sulting in the u	nderlying ca	iuse give	n in Part I.			oacco use con es ZINo		he cause of death? pably 4 □Unknown	
	Completed								24a. Was a autops perform	y ned?	Were auto prior to co death? 1  Yes	ppsy findings available mpletion of cause of	
Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:			Othe	11	of Death (Ch					
Phys r this ral dir	. To	1 193 2 140	28a. Date of Injury	28b. Time of		Bc. Injury	at			ince 6 □Ot		(y)	
or Attending Physafter death.  Director: After this in by the funeral di	Certification:	11/☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	Injury	м	Work 1 🗆 Y	? ′es 2□N	No				J. Pouto Mumber	
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral													
To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	one) 2 Medical Exeminer	on the basis of examination and manner stated.	ation and/or in	vestigation,	in my op	inion, death	h occurred a	t the time, da	ate and place	, and due to	the cause(s)	
To To		29b. Signature add title of certifier  29c. License number  29d. Date signed (Month, Day, Year)									oay, rear)		
		30. Name and address of person who comp				, su	ITE 5	, EAST	CON, M	D 2160	1		
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature #	Son	No.							
HMH 17 Rev 1/2	2001	MAI - 3	- July	-	1								

			1 - For Registrar	State of Marylan	d / Depa	artment o		and M			0 4	15829
	Physici	an	Decedent's Name (First, Middle, Last)						Date of Death     Month		Year	3. Time of Death
1	/Medic	cal	Lawrence Michae			41 O'L T.			April	T	004	8:10 P M
	Examin	er	4a. Facility Name (If not institution, give s				wn, or Location			4c. County o		instan
27	Funeral		Homewood Retirem  5. Social Security Number 6. Sex		last birthday)	If Under 1 Y		24 Hrs.	8. Date of Birth		9 Birthol	ngton lace (State or Foreign
	Director		705-10-6584 XX	(M 2□F 88	Yrs.	Months D	ays Hours	Min.	8. Date of Birth June 8,1	915	Coun	ary land
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10	0d. Inside City Limits
	Maryli f aho	ō	Maryland Washin									1 ☐ Yes 2\X\No
	r 28a-	Director	10e. Street and Number	ig ton	VV	10f. Zip Co			10	g. Citizen of W	hat Coun	try?
	th with	al D	16510 Virginia A	venue			217	795			USA	1
	ems ems	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent	t of Hispanic Ori Cuban, Mexican	igin? (Spe	crfy Yes or No- Rican, etc.)		- America	an Indian,
36	s afte	y Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 🕅				Specify:		
21215-0036	within 72 hours after death with the Maryland ene. Than "ratural", or Items 23a or 28a-f ahow tra Madical Examirer must be notified at	Completed by	15. Decedent's Educ	Year or Dates:	16a Deced	dent's Usual O	ccunation		1	6b. Kind of Bus		/hite
215	hin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	kind of work of DO NOT use r	lone during mos etired)	st of working	ng	00. 14		John
21	filed witl Hygiene other the	mo:	8	College (1-401 54)	1	Machin <u>i</u>	st			Ra	ilro	ad
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle, M	aiden Sumame	)	
<u> </u>	d Men narke	5		agunier	405 14 18	- 111 10		lith_	Alice			
Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of them 27 is marked other than "natural", or ltems 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinations to collect the profiled at Once.		19a. Informant's Name/Relationship (Type Clyde L. Bragunie						i amsport			
ō,	Heal Heal tem 2	1 3	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	of			Mary I a. 0c. Location - 0		21795 wn, State
Baltimore,	Pages ent of nt: If I		1 🔀 Burial 2 □ Cremation 3 □ Re  `4 □ Donation 5 □ Other (Specify)	emoyal from State	•	natory or other		10.4 7	2004			
a E	mit. I partm porta y inju		21. Signature of June 11 Serve Cens	e /	CSS (CSS	Sharae A	tunery i	ty Home	,2004 _n e.P.A.	agersto	WIL.	Maryland
<u> </u>	Dermi Depa Impo any id		11/0/0 11/0	Xul-					e St. Wi	lliamsp	ort,	MD 21795
	Physician /Medical		23a. Part 1. Enter the disease, or complic shock, of heart failure. List only on Immediate cause (Final disease of condition resulting in death)	eations that caused the deatle cause on each line.	UES	MOIC		cardiac o	r respiratory arres	st,	1	Approximate Interval Between Opper and Death
20	Examiner			-311 322 0	301100 01).							
///	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of).							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	uagas of):						_	
760,	ate be executed hysician and he burial-transit	cal E		Due to (or as a consequ	dence or).							
	ficate phys s the		d.									
Вох	leath certificat attending phy I for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. if yes, outcome of pregna						23d. Date	of deliver	ry
O. B	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown		Ectopic pregn Other (specif				Mont	n E	Day Year
ď.	res that igned b be deta	by Pt	Part II. Other significant conditions cont	tributing to death but not resi	ulting in the ur	derlying caus	e given in Part I.		23e. Did toba	cco use contrib	ute to the	e cause of death?
ğ	w require been sig should b	ed t	CHROVIC CHAIN	tocetic c	Cu/C	unca	WITH		1 🗆 Yes	2 □ No 3	☐ Proba	ably 4 Bunknown
Records,	ne law re has be ge 2 sho	Completed	HEMOCYTIC AVI	MCA AN	ENO CH	LCM	MH at		24a. Was an autopsy	24b. We	ere autop	sy findings available appletion of cause of
		Con	PRUSTATE LEWI	HUSCONA.	OMNY	hylho	1644 NI	(CAG	performe 1 ☐ Yes 25	ed? de	ath? Yes 2	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ancital:			0.11	-	(Check only one)			
ō	Attending Physician: r death. ector: After this certifica by the funeral director. F	. 10	1 Yes 2 No	ospital: 1  Inpatient 2  28a. Date of Injury	ER/Outpatient 28b. Time of				te 5 ☐ Residen 8d. Describe how			)
o	ding th. : After	tion	1 Statural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐ I		OU. Describe flow	rilliary occurred		
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, larm, stre	et, factory, of	lice	2	8f. Location (Stre City or Town,	et and Number State)	or Rural	Route Number,
Ω	To the Hospital or At within 24 hours after of To the Funeral Direct completely filted in by		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	wledge, death	occurred at th	ne time, date and	d place, a	nd due to the cau	se(s) and manr	ier as sta	uted.
	the H vin 24 the Fu npletel	<b>fedical</b>	0116)	er: On the basis of examinal and manner stated.	ion and/or inv			un occurre				
,	o To	×	29b. Signature and tute of certifier	War X		29c. Lx	sense number		290	Date signed (	Month, D.	ay, Year)
	7		30 Name and address of a result of	METJICAZ ()	METAL 2321 TURA	Print) 4	V110	(6)	1	MINICO	-11	(004
	ı		30. Name and address of person who can	ETCULA, (M)	74	Slon	THERN	ALE	- HACO	ENSTERN	N, C	Uf
of.	Sta		31. Date liled (Month; Day, Year)	32. Pargistrar's Signa	ture A	este		1		· · · · · · · · · · · · · · · · · · ·	19,	1705
	Registr	वा	APR 3 0 20	U4 Linker	N. 10%						//	/ / /

State of Maryland / Department of Health and Mental Hygiene [] [] [] 15830 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year 08:31A M Carl Steven Brown Sr. 27,2004 HOLLI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hagerstown

| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Washington County Hospital Washington 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F Yrs. Director 216-30-3008 69 June 6,1934 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 ☐ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or items 23a 914 Antietam Drive 21740 death USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Itel Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Miller and Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Anderson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert F. Brown Sr. Helen Kincses Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mae J. Brown/Wife 914 Antietam Drive, Hagerstown, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages ' Department of I-Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4/30/2004 Hagerstown, Maryland 21. Signature of Euneral Service 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** rdiovascula pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed iabetes that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death Check only one) examiner? 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune (Check only one) 29b. Signature and title of dertifie 29c. License number 29d. Date signed (Month, Day, Year) APRIL 27, H40884 Washington County Hospita) Hagerstown, MD 21740 eath (Ite 23a) (Type, Print) 30. Name and ad e of person who completed cause of

Registrar

Thomas 31. Date filed (Month AP)

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DHMH 17 Rev 1/2001

32. Registrar's Signature

			1 - For State Registrar	State of Ma		partment of Fertificate of			/ III lu	15831	
	-		Decedent's Name (First, Middle	e, Last)		ortinoate or	Death	2. Date of Death	. No	3. Time of Death	
	Physici /Medio	cal	BRUCE ORMAND	BIVENS				april c	27 2004	11:59 M	
	Examin	ner	4a. Facility Name (If not institution				r Location of Deat		4c. County of Death	ITNOMON	
F	uneral		WASHINGTON COL  5. Social Security Number		e (In yrs. last birthd	ay) If Under 1 Year	AGERSTOW If Under 24 Hrs	8. Date of Birth	9 Birth	INGTON  place (State or Foreign	
	irector		183-12-1508	1 <b>∑</b> M 2□F	82 Yrs	Months Days	Hours Min.		ear) Cou	SYLVANIA	
pur	3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					
Manyla	f show	ō	,	FULTON	. so. oxy, rown or		E TANNER	v		10d. Inside City Limits 1 ☐ Yes 2 🏋 No	
the	28a-	rect	10e. Street and Number	ODION		10f. Zip Code	C LAMMER		. Citizen of What Cou		
h with	23a o	ai D	2319 BIG COVE	TANNERY ROAI	D		17212		U.S.	•	
be filed within 72 hours after death with the Maryland	"natural", or Items 23a or 28a-f dical Exarch et matility	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H     If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - American Indian, Black, White, etc.		
s afte	l o	by FL	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	1941– 1945	1□ Yes 2∏ No	Specify:	,	Specify:		
P Poli	atural	ted t	15, Deceden	t's Education	1000	cedent's Usual Occup	ation	16	b. Kind of Business/In	LITE dustry	
thin 7:	e s	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5	- life	ive kind of work done i e. DO NOT use retired	during most of woi f)	rking			
ed with	t. Ite	Con	8			FARMER			DAIRY	FARM	
D edi	and Mendal hygiene. Is marked othar than aumatic evant, the M	Be	17. Father's Name (First, Middle, HARRY R. BIVEN	•				ne (First, Middle, Ma	iden Sumame)		
should	mark	2	19a. Informant's Name/Relations		19b M	ailing Address (Street	MYRTLE		ity or Town State 7in	Corfo)	
and 2 s	27 is r trau		NANCY YOUNKER,	, , , , ,		2 BIG COVE				1/414	
es 1 a	itam 27 itam 27 r othar tr		20a. Method of Disposition		20b. Place of Dis	sposition (Name of		Date 20	c. Location - City or To	own, State	
Pages	ant: If		1  Burial 2  Cremation  '4  Donation 5  Other (S	pecify)	CHURCH	TRIDGE CHR CEMETERY		)/2004 BI	G COVE TAN	NEW PA	
permit.	Important: If it any injury or o		21. Signature of Funeral Service			22. Name and Addres	s ol Facility	87	5 Lincoln	Way East	
<u>. a.</u>	2 8 0		David L. St			IOWARD L. S					
/IV	/sician ledical aminer		23a. Part1. Enter the disease, or shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Kes	a consequence of):	ory it	suf	icitus 10808	er colon	Approximate Interval Between Onset and Death	
ecuted	and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):		7				
icate be executed	physician and s the burial-transit	dicai Ex	resulting in dealing Last	d	a consequence of):						
		Φ 1	IF FEMALE:	1		_					
The law requires that the death certif	by the attending parched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date ol delivery Month Day Yea		
s tha	igned be det	by P	Part II. Other significant condition	ns contributing to death be	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to th	e cause of death?	
equire	been sig							1 ☐ Yes	2□No 3□Prob	ably 4 □Unknown	
The law r	has Je 2	Completed						24a. Was an autopsy performed 1 Yes 2.2	prior to cor death?	osy findings available inpletion of cause of	
ician	certificate rector, pag	Be	25. Was case referred to medical examiner?	Haspitali		Otho		th (Check only one)			
P y	si di	To I	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie	and the second s		# 🗆 Nursing m	ome 5 Residence	e 6 Other (Specify	)	
oding 4	: After I	ation	1 Natural 5 Pendin 2 Accident investig		Year) Injury	/ Work	? ′es 2 □ No	Edd. Describe flow f	illury occurred		
l or Atte	Diractor	Certification:	3 Suicide 6 Could r 4 Homicide determ	28e. Place of Inju- building, etc	ury - At home, larm, c. (Specify)	street, factory, office		28l. Location (Stree City or Town, S	t and Number or Rura tate)	Route Number,	
To the Hospital or Attending Physician: within 24 hours after death	To the Funaral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or	ath occurred at the tim investigation, in my op	e, date and place, inion, death occur	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)	
To th	To th comp	Me	29b. Signalate and title of certifier		//	29c. License	number	29d.	Date signed (Month, I	Day, Year)	
15	11		o//la	10 K	Corch	D	5033	7	+-28-	04	
ď	15		Dr. Kross	who completed cause of de	East	Detutan	It.	Itra p	r d		
gi.	Sta Registr		31. Date liled (Month, Day, Year) APR 2	32. Ragistra	ar's Signature	perti	7				

State of Maryland / Department of Health and Mental Hygiene 2004 15832 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician BUSER RONALD 24 12:45 M 04 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Heart umberland Allegany sacred If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. DECOMP. 13, 1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months MARYLAND 232-60-7464 66 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov 27 is marked other then "naturel", or Iteme 23a or 28a-1 sho treumatic event, the Medical Exercitor must be notified at RIDGELEY 1 Yes 2 □ No MINERAL WV Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26753 198 MAIN STREET U.S.A. death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 156-160 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiens. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industr (Specify only highest grade completed) KELLY-SPRINGFÍELD Elementary/Secondary (0-12) College (1-4or 5+) TIRE COMPANY FACTORY WORKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IRA BUSER EDITH BOWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Heelth an Item 27 is RENA BUSER / WIFE P.O. BOX 1230 - RIDGELEY, WV 26753 20a. Method of Disposition

1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ite
any injury or ot SUNSET MEMORIAL PARK 04/27/2004 CUMBERLAND, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCREATIC **Physician** YR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 Yes 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1: Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. I Director: After ( After t Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours aft To the Funerel Di 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier APRIL 25, 2009 D23714 and (muengood m) IVA 110 Name and address of person who completed cause of death (Item 23a) (Type, Print) SETON DRIVE CUMBERLAND MD 912 LIVENGOOD MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 8 2004 Registrar

# Maryland 21215-0036

		Please Type or Print in Black I		•	•				
	•	State of Maryland / Dep State of Maryland / Dep	partment of Health and Mert <b>Mic</b> ate of Death	lental Hygie Rag.	4004	15833			
Dhariaia		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death			
Physicia /Medic		Mary Italene Layman Bur		April &	26 2004	12400 M			
Examine	er	PENINSULA RAGIONAL MEDICAL CENTU	4b. City, Town, or Location of Dealh  SAUSBURY		4c. County of Deat	100			
Funeral Director		5. Social Security Number  6. Sex 1 M 2X F  7. Age (In yrs. last birthda Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye November 14		nplace (State or Foreign untry)			
pui »		Usual Residence of Decedent         10c. City, Town or           10a. State         10b. County         10c. City, Town or		TENSILE I	*/ 1.21.7	10d. Inside City Limits			
ath with the Marylar 23a or 28a-f show	lor					1 Yes 2 No			
th the	Director	Florida Volusia Daytona 10e. Street and Number	10f. Zip Code	10g.	10g. Citizen of What Country?				
ath wii		405 Revilo Boulevard		USA					
after death w	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White					
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d Men d Men marke	မ	Nelson Browning Layman  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Julia  ling Address (Street and Number or Rura	Constan					
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es 1 a of Hea of Hea fitem		20a. Method of Disposition 20b. Place of Dis			. Location - City or				
Pag tment tent: h		`4 Donation 5 Other (Specify) Odd Fe11	ows Cemetery May 3	, 2004 Di	uQuoin, I	llinois			
permit Depar Impor any in once.		21. Signature of Funeral Service Citiensee	22. Name and Address of Facility Holloway Funeral H	ome Profe	ssional A	ssociation			
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Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition RIGHT CE)	REBELLAR	INFAR	CT	Interval Between Onset and Death & DAYS			
/Medical Examiner		resulting in dealh)  Due to (or as a consequence of):		<del>- · · · · · · · · · · · · · · · · · · ·</del>		<u> </u>			
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The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	hysician/M		Other (specify)		Month	Day Year			
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w requires that been signed I should be det	ed by	CAROTID ARTERY STE	N0512	1 ☐ Yes	2 ☑ No 3 ☐ Pro	bably 4 Dunknown			
e law requ has been ge 2 shoult	ompleted	ASPIRATION PNEMON	IA	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of			
	O	DEHYDRATION		performed 1 ☐ Yes 2 ☑	l? death?				
ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Mo  Hospital: 1 ☐ Impatient 2 ☐ ER/Outpati	Othor	(Check only one)	0 Flow (0	*.			
Attending Physicien: or death. ector: After this certification by the funeral director,	on; T	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how i		lly)			
tendir leath. lor: Af the fur	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No						
or At after d Direct in by	Certificati	4 Homicide determined determined 28e. Place of Injury - Al home, farm, s building, elc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,			
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.			
the Ho in 24 the Fu	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.				``			
To To Com	Σ	29b. Signature and title of certifier  Youlder, M	29c. License number  29c. License number	62 A	Poll C	Day, Year)			
6		30. Name and address of person who completed cause of death (Item 23a) (Type M · SHIRAZI, M.D. PENIN							
Sta	_		Sporks		MI	21801.			
Registra	ar	7	Land						

		State Registrar Amend #2per		SL,5/	7/0 <i>4</i> Ce	rtificat	e of L	Jeath	- 1	2. Date of De	Rag. No		15831 04 3. Time of Death	
Physician	-	John R. Boyd	.431/							Month		5/04/20 2 <del>004</del>	1:41 A M	
/Medical		4a. Facility Name (If not institution, g	ive street and numb	per)		4b. City,	Town, or	Location of		May	_	4c. County of Death		
±xaiiiiioi	ı	Frederick Memori	al Hospit	al		Fred	lerio	k			F	rederio		
Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7 1⊠M 2□F	. Age (In yrs.		If Under Months		If Under Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Bir	rthplace (State or Foreign ountry)	
Director	- 1-	017-28-1550 Usual Residence of Decedent	18 20.	66	Yrs.					July 1	4, 1	937 Mas	sachusetts	
land iow	- 1	10a. State 10b. County		10c. Ci	y, Town or L	ocation							10d. Inside City Limits	
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72 hours after death with the Maryland neture!; or ltems 23e or 28e-f show near Examiner must be multified at steed by Euroran Director	5	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	ountry?	
239 x 239	2	5766 Katsura Co				217						ted Sta		
Items		<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Deced	ent Ever in U es? !□No 195	.s. 13.	Was Deced	ent of Hi ofy Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi		
of, or	2	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dat			1 ☐ Yes	2X No	Specify:				Specify: Wh	nite	
ygiene. ner then "netur it, ire Misicali	2	15. Decedent's (Specify only highest of		-	16a. Dece	dent's Usua kind of wo	al Occupa	ation during mos	t of workir	na	16b. K	ind of Business	s/Industry	
then "r	<u>.</u>	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	DO NOT us	se retired	)			M.C.			
her th	5	12 17. Father's Name (First, Middle, La	ct)		Senio	r Acc	ount			e (First, Middle	Maiden		unications	
Mental H mrked oth atic even	0	Ralph	ui,	Boyd				Mary	, 5 Manio	(r not, made		Matthew	19	
2 E E	=	19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ng Address			or Rura	l Route Numb			Zip Code)20874	
alth ar 27 is r treu	-	Scott Boyd / So	n									own, MA		
of Heg		20a. Method of Disposition	DD-mount from Ct	20b. I	Place of Disp cemetery, cre					ate		ocation - City or		
rtment or rtent: If njury or		1 ⊠Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Control of Contro		alb	thaven			1	/6/0	4	Free	derick,	Maryland	
Department of I		21. Signature of Funeral Service Lie	ensee	+								ral Hom		
스트 등 의	4	23a. Part1. Enter the disease, or co	Jes	01	-							ck, Mar	yland 21702 Approximate	
the has been signed by the attending physician and many many and many many many many many many many many	Sa	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease of Fjury that initiated events resulting in death) Last	a. Due to (o	r as a consec	quence of):								Interval Between Onset and Death	
the attending priched for use as the	iysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta ntattime of d	al death 3 i	□Ectopic pr □ Other (sp						23d. Date of de Month	livery Day Year	
b ed	2	Part II. Other significant conditions	contributing to dea	ith but not res	sulting in the i	ınderlying c	ause give	en in Part I			tobacco u Yes 2		o the cause of death?	
page 2 should I	ompiere					***************************************				24a. Was auto perfe 1 □ Yes		24b. Were a prior to death?	utopsy findings available completion of cause of s 2 \( \text{No} \)	
certifical	a l	25. Was case referred to medical examiner?	/	,					of Death	(Check only	оле)			
SE P		1 ☐ Yes 2 ☑ No			ER/Outpatie			4 🗆 NU				6 □Other (Spe	ecify)	
After funer	0	27. Manner of Death  1 Matural 5 ☐ Pending  2 ☐ Accident investigat		Day Year)	28b. Time o Injury	or 2	8c. Injury Work	at t? Yes 2 □		28d. Describe	now injur	y occurred		
itter death Director: in by the	ertifical	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place o	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, st fy)					28f. Location ( City or To			ural Route Number,	
24 hours a Funerel I etely tilled	Medical C		Physician: To the base aminer: On the base and manne	is of examina										
within 2 To the	Z	29b. Signature and title of fertifier				290	. License	number			29d. Dat	te signed (Moni	th, Day, Year)	
		) IM		_		[	2000	2951			5	10/0	4	
+1		30. Name and address of person when 201 Thomas	Johns	on	Drive	Print) Ma	rk P	Rub	in K	rederi	K	Mb	21702	
State Registra		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature	4	1	- 1	1					

			_ State	State of Maryland		artment of H		nd Mental H		2001	. 15025
			Registrar  1. Decedent's Name (First, Middle, Last)		001	incate of	Deain	2. Date of		_00	3. Time of Death
	Physicia		GRODESE.	. W.	130	ZNEas	n 5	R. April	Day 29	2004	03:54 AM
*	/Medic Examin	_	4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, o	r Location o	f Death	4c. Co	ounty of Death	h
			The Johns Ho	Okins tesp	tral	Balti	MON		/		
	Funeral	ľ	5. Social Security Number 6. Set 15	7. Age (In yrs. II M 2□F 67	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		0 193	6 9. Birth	nplece (State or Foreign untry)
H	Director	-	Usual Residence of Decedent		11.50			70-			OHIO
	yland		10a. State 10b. County		, Town or Lo	cation					10d. Inside City Limits
	e Ma-f s	Director	MD WASHING	TON HA	GERSI				1		1 □ Yes 2 No
	vith th	Dire	10e. Street and Number 9891 CROSSFIELD	DOND.		10f. Zip Code 2174(	`			n of What Col SA	untry?
	72 hours after death with the Maryland natural; or ttems 23a or 28a-f show disal Examinar must by mutified at	Funerai			S 13.V			nin? (Specify Yes or		Race - Amer	rican Indian,
	fter d	Fun	1 Never Married 2 Married	2. Was Decedent Ever in U.: Amed Forces? 1 BYes 2 No 195	6 '	f Yes, specify Cub	an, Mexican	, Puerto Rican, etc.)		Black, White	
5-0036	ours af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1966		1 ☐ Yes 2 🕅 No	Specify:		Sı	pecifyWHI	TE
<del>ر</del>	72 hours af	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working		of Business/I	
121	within ene then "	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		PATCHER	u)		ROCK		CRUSHED
א ס	filed Hygi other	a)	12 17. Father's Name (First, Middle, Last)					r's Name (First, Midd	dle, Maiden Su		
ian ian	o g a p	To B	WALTER C. BENEA	.R			CLA	RA JOHNS	ON		
Maryland	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (Type					r or Rural Route Nur	-		
	is 1 and of Health item 27 othar tr		LEATHA BENEAR /			CROSSF .	LELD	RD., HAG	-	tion - City or	
altimore,	0 0 = =		1 ☐ Burial 2 Cremation 3 ☐ Re	emoval from State	emetery, crer	natory or other pla		5/3/04	-	ERICK	
		1	*4 ☐ Donation *5 ☐ Other (Specify)  21. Signature of Fundam Service Licende			2. Name and Addre			TREE	DRICK	, IID
m	permit. Departr Importa any inju	4	1 All HIA	1	I	HILTON	TUNER	AL HOME	. T. T. T.	MD	20838
d			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	n. Do not ent	er the mode of dyi	ng, such as	cardiac or respirator	arrest,	MD	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mrocan	dia	L In	Can	ction		-	3 weeks
*	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
Н		-a	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c								
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
3760	2 2 2	ical	<b>€</b> d								
9 ×	ertifica ling ph e as th	Med	IF FEMALE:	3c. If yes, outcome of pregna	no.				-	4 5-4	
Вох	leath certific attending p	Physician/M	in the past 12 months?	1 Live birth 2 Fetal	Ideath 3	Ectopic pregnanc Other (specify)	у		230	d. Date of deli Month	Day Year
o.	that the de led by the a detached i	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
٥.	The law requires that the ate has been signed by th page 2 should be detache	by PI	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. D	d tobacco use	contribute to	the cause of death?
Records,	w requires been sign should be							1	Yes 2 🗆	No 3 Pr	obably 4 Minknown
ecc	e law r has be je 2 sh	Completed							topsy	prior to d	topsy findings available completion of cause of
<u>~</u>	cate h	Con						1□ Ye		death?	250
Ž.	Physician: The la r this certificate has rral director, page 2	o Be	25. Was case referred to medical examiner?	lospital:	ER/Outpatier	- 35 pos   Ott	200	of Death (Check on		TOther (See	
Division of Vital	y Physer this eral di	1-	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	28b. Time o			rsing Home 5 A	e how injury o		siy)
ion	Attending or death.  ctor: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2	No			
ivis	of or Attendated after death	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	reet, factory, office			n (Street and I Town, State)	Vu <i>mber or R</i> u	ıral Route Number,
Ω	oital or urs afte oral Dir		No. of the state o					d =1=== ===d di= 0 = 0			
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	me, date an opinion, dea	d place, and due to t th occurred at the tin	ne cause(s) ar ne, date and pl	ace, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c, Licen	se number			signed (Month	
	. , , , ,		DE Som MO			RE	5-00	v	April	29, 7	2004
9	12		30. Name and address of person who co ERIC SCHMIDT MD JOHNS	mpleted cause of death (Item	23a) (Type,	Print)	E STRE	ET RAITE	аль М	Ae Vida	D 21287
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		OKIN WOLF	4	- DALIN	Orce let	I TO TONIO	
	Regist		· ·	2006 Sens	are .	B 1	oak				

		1 - For State Registrar	State of M	aryland / [	Depari <i>Certi</i>	tment of H	lealth a Death	and M	ental H	ygiene Reg. No		) 4	15836
		Decedent's Name (First, Middle, Last)							2. Date of [	Death			3. Time of Death
Physici /Medic		WALTER EUGEN	E BRACK	ETT					Mary	4, Da	2004	Year	8:56А м
Examin	er	4e. Fecility Name (If not institution, give s			4	b. City, Town, or				4c	. County o		
	-	18855 WICOMICO  5. Social Security Number 6. Sex		DR • ge (In yrs. last bir	eth da l	COB	B IS	)	CHARL ate of Birth Nonth Day, Year, N. 10, 1926 WA				
Funeral Director			M 2□F			donths Days	Hours	Min.	Month I	O Year)	26 V	VASE	lece (State or Foreigr fry) I • , D • C •
pu »		Usuet Residence of Decedent		140.00									
the Marylan r 28a-f ahow notified at	ō	MARYLAND CHARL	FC	10c. City, Tow	n or Locat		BIS	T.ANT	١			10	0d. Inside City Limits 1 ☐ Yes 2 ② No
the N 28a-	Director	10e. Street and Number				10f. Zip Code	17, 10	77 57 14 17		10a. Cit	izen of Wh	nat Coun	
death with the Maryland ms 23s or 28s-f show rmust be notified at	a D	18855 WICOMICO	RIVER D	RIVE			625				U.S.A.		
	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		in U.S. 13. Was Decedent of Hispanic Origin? (Sp					10-	14. Race	- America White, 6	
72 hours after natural', or Ite	by Ft	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 XYes 2 ☐ If Yes, Give	ARMY		Yes 2 No	Specify:	,			Specify:		ITE
Phour		15. Decedent's Educ	real or Dates.	WWII-	Deceden	t's Usual Occupa	Occupation 16b					iness/Ind	
- 3	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or		(Give kin	d of work done o NOT use retired	furing most	of workin	g				wony
be filed within tal Hygiene. d other than "	Corr	8			AIRL	INE ME	CHAN	IC		AME	RICE	N A	IRLINES
2 should be filed within and Mental Hygiene. is marked other than aumatic event, I'm M	Be	17. Father's Name (First, Middle, Last)  WILLIAM B	D <b>አ</b> ር ሂ ፑ ጥ ጥ						(First, Midd		Sumame,	)	
should ind Men in marke umatic	은	19a. Informant's Name/Relationship (Typ			Mailing	EMMA MAY FINK  Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							Codel
and 2 sealth ar n 27 in ver trau		BRENDA S.JONES-				EDGE							0664
of Hear		20a. Method of Disposition		20b. Place of cemeter	Disposition	on (Name of ory or other place	e)	Da	ite	20c. Lo	ocation - C	ity or Tov	wn, Stete
Peges ment of I ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	M	D. VETE	-			5-10	-04	CHE	LTEN	HAM	,MARYLAN
permit. Peges 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic every Inc.		21. Signature of Funeral Service License	M004	79	22 N RA	ame and Addres	s of Facility FUNE	RAL	SERV	ICE,	P.A.		
102 C		23a. Pert1. Enter the disease, or complic	cations that caused	d the death. Do o	LA	PLATA	MAR	YLAN	D 20	646			Approximate
Di		shock, or heart failure. List only on Immediate Cause (Final	e cause ach li	ine.				Dai Giac Oi	103piratory	a1163t,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as	a consequence		ANCEI	<					-	HEARS
Examiner	_	Constraint link that are distance.			.,.								
P E	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):								
executed in and ial-transit	Examiner	that initiated events resulting in death) Last	a consequence	quence of):									
be trie			000 10 (0) 23	a consequence	O1).								
ificate I g physi as the t	edical												
h certific ending p	In/M	230. Was decedent pregnant	3c. If yes, outcome	of pregnancy 2 Fetal death	3□50	topic pregnancy					23d. Date	of deliver	у
requires that the death certificate seen signed by the attending phys hould be detached for use as the	Physician/Me	in the past 12 months?	4□Pregnant at			ther (specify)					Month	) [	Day Year
that the de ned by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions con		out not reculting in	the unde	shring agues gues	n in Dani I		220 Did	tobacca u	an anataib	uto to the	and death?
uires ti signe Id be c	d by	CORONANY					in in Part I.			,1			e cause of death?
> 10 (0	Completed	ANEMIA							24a. Wa		1		
e la has	dwc	AICEILIA							auto peri	opsy formed?	pride	or to com th?	sy findings available pletion of cause of
sician: Th certificate rector, pag	· eu	25. Was case referred to medical					26. Place	of Death (	1 ☐ Yes Check only	one)	1	Yes 2	No.
Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	ospital: 1  Inpatie	ent 2 ER/Ou	tpatient	3□ DOA Othe			e 5⊠Res		6 Other	(Specify)	
fter ng		27. Manner of Death 1. Selection 1. Selecti	28a. Date of Inju (Month, Da		ime of njury	28c. Injury Work			ld. Describe				
Attending It death. sector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	ORa Blace of Inc	us. Athens fo			res 2□N		M Location	/C44	4 82 4	5	
l or Atten after deati Director: I in by the	Certification:	4 Homicide determined	building, et	ury - At home, far c. (Specify)	rm, street,	factory, office		28	City or To	(Street and own, State,	a Number )	or Hurai	Route Number,
To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge	, death oc	curred at the tim	e, date and	place, an	d due to the	cause(s)	and mann	er as sta	ted.
To the Hos within 24 h To the Fur	fedical	one)	and manner sta	ated.	wor invest	· · · · · · · · · · · · · · · · · · ·		n occurred	at the time				
To To Con	Σ	29b. Signature and title of certifier	B			29c. License D-48					e signed (/	-	ay, Year)
				) /	Time Di					3/	15/	7	
10		30. Name and address of person who cor Richard E Branso	dorf, M	D 12070	) 01	d Line	Cent	er a	#100	Wald	lorf	, MI	20602
Sta	te	31. Date filed (Month, Day, Year)		ar's Signature									
Registr		MAY 182	004 /	our &	B	estis							
IMH 17 Rev 1/20	001				-								

Physician /Medica Examiner  Funeral Director	n il -	Decedent's Name (First, Middle, Last)  Lena Grace									100	1 1 000	- LUUJ
Examiner Funeral Director			e Bussa	rd_					2	Date of Dead Month Apr •	Day	) 04	3. Time of Death A 11:55
Director		4a. Facility Name (If not institution, give s 8121 Rocky Spri	ings Rd	i		Fı	ced	Location of	τ			eder	
•how		5. Social Security Number  214-28-2449  Usual Residence of Decedent	M 25	Age (In yrs. la	st birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min	Date of Birt (Month, Da pr •	v. Year)	Cour	
2 -		10a. State 10b. County  MD Frede:	rick	10c. City,	Town or Lo	reder	cic	k					0d. Inside City Limi 1 ☐ Yes 2 🙀
with the Mar 3a or 28e-f el 1 be notified		10e. Street and Number 8121 Rocky Spi	rings R	≀d.		10f. Zip (		703			10g. Citizen of V		itry?
Lisa of	by rur		12. Was Deceder Armed Force 1 Tyes 25 If Yes, Give Year or Dates	nt Ever in U.S s? No		Was Decede		spanic Orig n, Mexican, Specify:	in? (Specit Puerto Ric	y Yes or No can, etc.)	. 14. Race Blac Specify	k, White,	an Indian, etc. ite
J within 72 ho plene. r than "natur the Modical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual kind of work DO NOT use ashie	done d retired	ation during most	of working		16b. Kind of Bu		·
Hal H	o Be Co	17. Father's Name (First, Middle, Last)  Adam L. Keet	ney Sr.			азпте	3L		1975	irst, Middle,	Meiden Sumam		
d 2 shoith and h		19a. Informant's Name/Relationship (Ty) Robert Bussard									er, City or Town, ederick		Code) <b>D</b> 21702
permit. Pages 1 an Department of Heal Mportent: If item 2 any injury or other ance.	-	20a. Method of Disposition  y □ Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)		20b. Pla	aca of Dieno	natory or oth	o of	1	Date	Α	20c. Location · Middlet	City or To	wn, State
permit. Pa Departmer Importent: eny injury once.		en Significa in fundial Scruix Ucense	11/5		3	1_E.	Ma:	in St	, N	liddl	neral H etown,	Iome MD	21769_
ysicien and he burial-transit	Ical Exam	23a. Part. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a Due to (or a A + 1)	as a conseque	ence of):  Oho: ence of):	stru	Que ctu	l ma	ulm	any	st due	ce C	Approximate Interval Bottween Onset and Death / Court
at the death certifical by the attending phytached for use as the street of the second	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal of dea	death 3□	Ectopic pre Other (spe					23d. Date Mor	e of delive	ry Day Year
quires that an signed by and be deta	፭	Part II. Other significant conditions cor				nderlying ca	A	en in Part Ì.				ibute to th 3 <b>⊠</b> Prob	e cause of death? abiy 4 □Unknow
eicien: The law requires t certificate has been signe rector, page 2 should be o	Completed									24a. Was autop perfo 1  Yes	rmed? D	rior to cor eath?	psy findings availab npletion of cause of 2 No
	9	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpa	atient 2□E	R/Outpatier	nt 3□ DO/	Othe			Check only o 5 ► Resid	ne) dence 6 ⊡Othe	er (Specify	·)
	atlon; I	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o Injury	f 28	lc. Injury Work	rat <br Yes 2 □ N	lo		now injury occurre		
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Alte completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At hon etc. (Specify)	ne, farm, str	eet, factory,	office		281	Location (S City or Tox	Street and Numbe vn. State)	er or Rura	l Route Number,
Hospi 24 hour Funer stely fill	edical	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the be ner: On the basis and manner	s of examination	rledge, deat on and/or in	h occurred a vestigation,	it the tim in my op	ne, date and pinion, death	l place, and h occurred	d due to the at the time,	cause(s) and mar date and place, a	nner as st nd due to	ated. the cause(s)
To the within. To the comple	Mec	29b. Signature and title of certifier	·arher	-RQ	ine	29c.	-	o number	97		29d. Date signed	(Month,	4
- 8		30. Name and address of person who co	empleted cause of	of death (Item	23a) (Type,	Print)	الم ك	rald	وربو	u Su	to 104.	FV	odoruk

	,	٠	For State Registrar	State of I	Marylan	d / Depa	artment of Hetificate of L	eaith and Moeath	Mental Hy	giene Reg. No. 2 0	04	15838
7	4		1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		PENELOPE DENI	SE CALT	RIDER				MAY 3,	2004		4:30 PM M
	Examin		4a. Facility Name (If not institution, give CARROLL HOSPITAL		ər)		4b. City, Town, or WESTMINS			4c. County		
SER	Funeral Director		5. Social Security Number 6. S 216-44-2140	9X 7. □ M 3.□F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day FEB. 12	, 1946	9. Birthpi Coun MAR	lace (State or Foreign try) YLAND
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation				10	0d. Inside City Limits
ALTRID	death with the Maryland ms 23a or 28a-f ehow rmat be notified at	ctor	MARYLAND CARRO	LL		NEW W	INDSOR		·			1 ☐ Yes 2 ☐ No
4	with th	Funeral Director	10e. Street and Number 3931 HOOPER ROAD	i			10f. Zip Code 2177	76		10g. Citizen of V UNITED		-
V	Jeath The 23	eral	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13. \	Was Decedent of His Yes, specify Cubar		pecify Yes or No-		- Americ	an Indian,
~ ×	or Itan		1 Never Married 2 Married	Armed Force 1 ☐ Yes X If Yes, Give	ΧNο		f Yes, specify Cubar I □ Yes 2 <b>XX</b> o	Specify:	Rican, etc.)		k, White, e	
EN!	tural,	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Date	s:	16a, Deced	lent's Usual Occupa	tion		16b. Kind of Bu		
DEN15	hin 72 Medic	Completed by	(Specify only highest gra	de completed) College (1-4d	or 5+)	(Give life. L	kind of work done di DO NDT use retired)	uring most of worl	king			
7	ind with	Соп	12			0	WNER/MANA		o (First Middle			E SALES
ENELOPE Ballimore Maryland	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  The propertiest of Health and Mental Hygiene.  The propertiest of the transpace of the than "natural, or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at ances.	To Be	17. Father's Name (First, Middle, Last) MALVIN CALTRIDER						HAINES			
CO	INICAL nd 2 sho lith and l 27 ie m		19a. Informant's Name/Relationship (GREGORY D. GREEN				g Address (Street a HOOPER RO				State, Zip 2177	
ENELO	Des 1 av cof Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ V2 Permation 3 ☐	Removal from Sta		emetery, cren	sition (Name of natory or other place		Date	20c. Location -	City or To	wn, State
\\ \frac{1}{2}  \frac{1}{2}	it. Pagirtment		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		CA		CREMATION  Name and Address		2004	HAMPSTE	AD, I	MARYLAND
(n) B	Depa Depa Impo Impo		Sun a 17-7	Porboit	Mul	040 M	YERS-DURB 91 WILLIS	ORAW FUN	ERAL HON	Æ,P.A.	D 3'	1157
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	olications that cause on each	od the death	h. Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			CF	ALLURO					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	ALLURO OF TI		11-0			
~	€.	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	uence of):	01- 71	HE LI	VER			
COL	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
O DE	cien puria	cal Ex	resulting in death) Last	Due to (or	as a consequ	uence of):						
687	y s			d								
0 0 0	ath cer ittendir	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 m of this? 1 □ Yes 2 Tho 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnan 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ry Day Year
۵	uires that the de signed by the a	y Ph	Part II. Other significant conditions of	-		_		n in Part I.	23e. Did to	bacco use contr	ibute to th	e cause of death?
901	w requires been sig	led b	RENAL FAI	LUCE	A-50	CITE	5, 5/P	CORONOR	24 10 Y	es 2 No	3 Proba	ably 4 Hinknown
Division of Vital Becords	sicien: The law n scertificate has be lirector, page 2 sh	Completed by	ARTERY BY	PASS	GRAI	75			24a. Was a autop perfor 1 22 res	sy p med? d	eath	osy findings available apletion of cause of
<u></u>		Be C	25. Was case referred to medical examiner?					26. Place of Dea				
,	Physicien: Physicien: this certificatel frail director, j	၉	1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 Inp		ER/Outpatien		4   Nursing re	ome 5 Resid	ence 6 Othe		)
5	ding P. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,	Day Year)	Injury	Work	? 'es 2 \_No	Zod. Describe II	ow injury occurre	<b>3</b> 0	
2	Atten er deal ector by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At ho	ome, farm, str	set, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,
Ë	itelor is after led in											
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical			s of examina		occurred at the time restigation, in my op					
	To the within To the compl∉	Me	29b. Signature and tipe of certifier	11.1			29c. License	number	2	29d. Date signed	(Month, L	Day, Year)
			1 Kell in	1-1	e) r	1	24	3453		May	5,	2004
	10		11 = 14	completed cause	deal (Ite	23a) (Type,	Print)	1,-		,		MINSTER
ı	Ψ Sta	te	31. Date filed (Month, Day, Year)	32. Reg	strar's Signa	ture ,	200	MENIE	RIALI	tve. U	1631	MINSTER
	Registi		MAY 1 8 200		enn	5	Spark	, :				

			For State Ragistrar				yland / Dep	partment of learning of the contract of the co	lealth and	Mental Hy	giene Reg. No. 20	04	15839
	Physicia /Medic	al	Decedent's Name (First, Roberta Rosi     Aa. Facility Name (If not ins	na Cai	ctee	mber)		4h City Town	or Location of Dea	2. Date of De Month	Day	Year Year	3. Time of Death
	Examin	er	Washington C 5. Social Security Number		Hospit	al	In yrs. last birthda	Hagerst	OWN	s. 8. Date of Bir	Wash	ingtor	1 ace (State or Foreign
	Funeral Director		219-05-2313 Usual Residence of Deced	ent	□M 20XF		92 Yrs.	Months Days	Hours Mir	04/01/	1912		MD
	e Marylan Be-f show	ctor	MD Wa	county Ishingt	ton	11	Oc. City, Town or Hagerst	own					d. Inside City Limits 1   Yes 2  No
	ath with the 230 or 2	Funeral Director	10e. Street and Number 1009 Potomac	Aven				10f. Zip Code 21742			10g. Citizen of USA		
999	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene is marked other than "naturel; or items 23e or 28e-f show eumatic event, the Marked Examiner invarior in titled.	by	11. Marital Status  1 ☑ Never Married 2[ 3 ☐ Widowed 4 ☐ Dir	_	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2X No ve	er in U.S.	I. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No		Specify Yes or No into Rican, etc.)	Specif	ce - America ick, White, e fy: Wh	
2	a. Modical	Completed			ucation de completed) College (	1-4or 5+)	16a. Dec (Gir life	edent's Usual Occu re kind of work done DO NOT use retira	oation during most of wi d)	orking	16b. Kind of B		
71 7 DIIB	t be filed with that Hygiene ed other that event, Inc.	Be	12 17. Father's Name (First, Manual Luther	Aiddle, Last)	_4_			Case Wor	18. Mother's Na	ame (First, Middle	, Maiden Surnar	1 Serv	vices
Maryie	ind 2 should alth and Me 27 Is mark ist treumatio	2	19a. Informant's Name/Re Gerald M. Dr	lationship (7	ype, Print)			iling Address (Street S. Potoma	and Number or F	Rural Route Numb	er, City or Town		
•	permit Pages 1 and 2 should be Department of Health and Menta Injury or other treumatic events any injury or other treumatic events.		20a. Method of Disposition  1  Burial 2	ther (Specify iervice Licens	see solications that one cause on a.	caused the each line.	Rose Hi	position (Name of ematory or other pla 11 Cemeter 22. Name and Address 305 N. Ponter the mode of dying the first second s	ess of Facility Country Stomac St	reet, Ha	Minnic Igerstow	h Fune	MD eral Home
-	icate be executed physician end s the burial-transit	edical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last	Si,	C.		consequence of):						
.O. DOX	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ant		birth 2 [ nant at tim	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of deliver onth E	y Day Year
r (SD)	quires that in signed b uld be deta	by	Part II. Other significant c	onditions co	ontributing to d	leath but r	not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	_		cause of death?
	The lavate has	Completed								24a. Was auto perio 1  Yes	psy ormed?	prior to com death?	sy findings available pletion of cause of
V11.d	rsicien: Th s certificate lirector, pag	o Be	25. Was case referred to r examiner? 1 ☐ Yes 2 ☐ No	- t-	Hospital: 1 🗷	Inpatient	2 ER/Outpat	ent 3□ DOA Ot	200	eath <i>(Check only o</i> Home 5 ☐ Resi		ner (Snecify)	
	or the Hospital or Attending Physicien: within 24 hours after death, as a fer death To the Funerel Director; After this certifica completely filled in by the funeral director,	ertification: T	27. Manner of Death  1 Natural 5  2 Accident	Pending investigation	28a. Date (Mor			of 28c. Inju		28d. Describe	how injury occur	rred	
ž Ž	To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director; After completely filled in by the funer	O	4  Homicide	Could not be determined	286. Place build	ing, etc. (	(Specify)	street, factory, office		City or To	Street and Numb wn, State)		
	To the Hospitel or within 24 hours afte To the Funeref Dit completely filled in	Medical	29a. Certifier (Check only 2 M one)  29b. Signature and title of	edicel Exam	iner: On the b	e best of r pasis of ex iner state	kamination and/or	ath occurred at the ti investigation, in my 29c. Licen	opinion, death occ	ce, and due to the curred at the time,	date and place,  29d. Date signe	and due to t	the cause(s)
	E E E E		> Ph	fre	and the				325/8 Leedynn		4/28/09	4	
5	4,	ate	30. Name and address of the state of the sta	derson who	5	21	th (Item 23a) (Typ  Wyand  s Signature	e, Print)	Ledyan	lle, mo	1 217.	56	

Registrar

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of H	ealth and Mental Hygiene

		•	For State Registrar	State of Marylan		artment of H			giene Reg. No. 201	15861
3	Physici /Medic	al	Decedent's Name (First, Middle, Lasi     ELEANOR MARIE     A. Facility Name (If not institution, give	COUTER		4b. City, Town, o	r Location of	2. Date of Dea		
1	Examin Funeral	er	1004 KENTUCKY  5. Social Security Number 6. Se	AVENUE	last birthday)	CUMBER	LAND	4 Hrs.   8 Date of Birt	ALLE	
9	Director		212-74-8630  Usuel Residence of Decedent  10a. State 10b. County	□M 20F 98	Yrs. y, Town or Lo	Months Days	Hours	Min. (Month, Da) MAR. 4,	1906	MARYLAND  10d. Inside City Limits
	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f ehow item Wadigal Exercitive must be motified at	Director	MD ALLEGA		MBERI				10g. Citizen of Wha	X Yes 2 No
	death with	Funeral DI	1004 KENTUCKY  11. Marital Status	AVENUE  12. Was Decedent Ever in U Armed Forces?	.S. 13.	21502	lispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc.
5-0036	ours after	P P	1 ☐ Never Married 2 ☐ Married 3 分 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XINo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	Public Production	Specify:	WHITE
21215-(	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f ehow appringuy or other traumatic event, the Madical Expression matches notified at once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired IMEMAKER	during most ( d)	of working	16b. Kind of Busin	ess/Industry
Maryland 2	ould be filed withi Mental Hygiene. arked other than atic event, the M	To Be C	17. Father's Name (First, Middle, Last)	SPIES				's Name (First, Middle, ISY VIOLA		
	and 2 should I salth and Meni n 27 is marke her traumatic		19a. Informant's Name/Relationship (7 WAYNE A. COUTER					or Rural Route Numbe		ute, Zip Code) 21502
Baltimore,	Pages 1 annent of Heanners If Item		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	emetery, crei	esition (Name of matory or other place NT CEMETE	·	Date 5/03/2004	20c. Location - Cit	y or Town, State LAND, MD
Balti	permit. Departn Importe eny inju		21. Signature of Funeral Service Licen	uncherce	) 2			RAL HOME, E		21502
	Physician /Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of the shock is the shock of the shock or condition resulting in death)	a. Conflictive Due to or or or or or or or or or or or or or	earl 3	er the mode of dyir	ng, such as c	ardiac or respiratory an	rrest,	Approximate Interval Between Onset and Death
	Examiner up	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq						
8760,	icate be executed physicien and s the burial-transit	Ical	resulting in death) Last	d	luence or):					
P.O. Box 6	death certif e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of c	I death 3	∃Ectopic pregnanc ∃ Other (specify) _	y		23d. Date of Month	
	signed d be de	b	Part II. Other significant conditions o	ontributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	.,	ute to the cause of death?  Probably 4 Unknown
Il Records,	The law ate has b page 2 s	Completed						24a. Was autor perfo 1 \( \text{Yes}	osy prio ormed? dea	re autopsy findings available ir to completion of cause of th? Yes 2 \to No
f Vital	Physiclan: rthis certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatie	nt 3□ DOA Oth	oac.	of Death (Check only of sing Home 5) Resid		(Specify)
Division of	ath. or: After	Certification:	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by		28b. Time of Injury	Wo	ryat rk? ∣Yes 2.∏.N	40	how injury occurred	
DIV	i di di		4 Homicide determined	building, etc. (Speci	fy)			City or Tox	wn, State)	or Rural Route Number,
	he Hospitel in 24 hours a he Funeral pietely filled	Medical	29a. Certifying Ph (Check only 2   Medical Exar	ysician: To the best of my kniner: On the basis of examination and manner stated.	ation and/or in	vestigation, in my	opinion, deat	h occurred at the time,	date and place, and	due to the cause(s)
	7 minimum 7	Σ	29b. Signature and title of certifier	Just -			3371		29d. Date signed (1	Month, Day, Year)
-	MRS		30. Name and address of person while 2 man.	completed cause of death (Ite	m 23a) (Type	Print) (Prente.	Cum	berland, n	1D 215	02
	St Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 6	Sparks				

<b>Physici</b>	an	1. Decedent's Name (First, Middle, L			ertificate of D		2. Date of Dea Month April 2	th Day Yea	3. Time of Dea
/Medic	al	FRANKIE LOU	CARROLL		4. 67. 7			7 Day 2004 Year 4c. County of De	10:10
Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or I		ain	1	lerick
Funeral			Sex 7. Age (In )	rs. last birthday	) If Under 1 Year				Birthplace (State or Fo Country)
Director		579-24-6914 Usual Residence of Decedent	1□M 2⊠F 80	) Yrs.	Months Days	Hours Mir	June 7		shington,
how		10a. State 10b. County	10c.	City, Town or I	ocation				10d. Inside City Li
Ba-f s	by Funeral Director		derick M	t. Airy					1 ☐ Yes 2 ≸
De De	Die	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	
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r Ite	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo		. Was Decedent of His If Yes, specify Cuban		erto Rican, etc.)	Black, W	hite, etc.
Department of Health and Mental Hygjene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Evantment Let indiffical at any injury or other treumatics.	t by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
dical	Completed	15. Decedent's E (Specify only highest g.	Education rade completed)	16a. Dec (Giv	edent's Usual Occupat e kind of work done du DO NOT use retired)	tion uring most of w	orking	16b. Kind of Busines	ss/Industry
than the	id III	Elementary/Secondary (0-12)	College (1-4or 5+)					0 11	
Hygie ther t	ပ္ပိ	17. Father's Name (First, Middle, Las	<u>Z</u>	H	omemaker	18. Mother's Na	ame (First, Middle, I	Own Ho	ome
ental Kedo ic eve	То Ве	William Robert Fi				Arlono	Bronson		
maring W	-	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street ar			, City or Town, State	e, Zip Code)
alth a		Louise C. Glasco	Daughter	1221.	5 South Del	bkay Co	urt, Monr	ovia, Mar	yland_217
of He	133	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	20	<ul> <li>b. Place of Disp cemetery, cri</li> </ul>	position (Name of ematory or other place	)	Date	20c. Location - City	or Town, State
ment ant: I ury o		`4 ☐ Donation 5 ☐ Other (Spec	ify) F1	t. Lince	oln Cemete	ry 5/4/	2004 B	rentwood,	Maryland
Depart Import any inj once.	l ii	21. Signature of Funeral Service Lice	ensee	/ 1	22. Name and Address Dlin L. Mo.	of Facility leswort	h P. A. F	uneral Ho	me
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		23a. Part. Enter the disease, or conshock, or heart failure. List only	nplications that caused the c y one cause in each line.	leath. Do not ei	nter the mode of dying	, such as cardi	ac or respiratory arri	əst,	Approximate Interval Betwee Onset and Dea
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Medical aminer		resulting in death)	Due to (or as a con	sequence of):					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Lest) Month 5 Physician Catherine Daggett mq00:8 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Chaste. Chester tows md If Under 1 Year | If Under 24 Hrs.
Months | Deys | Hours | Min. 8. Date of Birth (Month, Day, Oct 3 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 84 Maryland 212-01-6498 Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with tha Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28a-f show 1X Yes 2 □ No Funeral Director Kent Betterton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Ericsson Ave. 21610 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 6 White 1 ☐ Yes 2 X No Specify ģ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Heelth and Mental Item 27 la marked o James Mullaney Margaret Dietz 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Davis (daughter) 12 Carlin Lane Newark, DE, 19713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dapartment of H Important: If ite any injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/9/04 Kent Cremation Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. 21. Signature of Funeral Service Liansee Schaech M00510 118 West Cross St. Galena, 21635 23a. Part1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear! failure. List only one cause on each line. Onset and Death **Physician** Movement Disader /Medical Immediate Cause (Final disease or condition resulting in death) year Examiner Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificata be executed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown ementia 24b. Were autopsy findings available prior to completion of cause of death? 24 hours aftar deeth.

• Funeral Director: After this certificate has been si etely filled in by the funaral director, pega 2 should I 24a. Was an eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 ☐ Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Vithin 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10054890 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 6602. Church HM Rd Chatutra MD 21620 Heather Morphy M.D. Registrer's Signature 31. Date filed (Month, Day, Year)

MAY 1 3 2004 State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

		1 = For State Registrar		f Maryla		artment of H			R	eg. No.	004	15845
Physici /Medic		Decedent's Name (First, Middle, I  MIRIAM B	.ast) LSHOP DI	EAN					2. Date of Dear Month MAY	Day	<sup>Yeer</sup> 2004	3. Time of Death 2:35 P <sup>M</sup>
Examin		4a. Facility Name (If not institution, g  841 GREENVILLE I  5. Social Security Number 6.	ROAD		s. /ast birthday)	4b. City, Town, or CENTRE			8. Date of Birth	QUI	EEN ANN	
Funeral Director		215–38–0185 Usual Residence of Decedent	1  M 2 <b>X</b> F	98	Yrs.	Months Days	Hours	Min.	JAN. 5	Year)	MARYL	ace (State or Foreign try) AND
a Maryland a-f ehow	ctor	MD 10b. County QUEEN A	ANNE'S	10c. C	CENTR	extion EVILLE					10	0d. Inside City Limits 1 ☐ Yes 2 No
or 28	Olre	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Coun	try?
ath w	ra	841 GREENVILLE			1	21617					JSA	
portition of the state of the s	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 □ Yes If Yes, Giv Year or D	rces? 2 [ <b>X</b> No e		Was Decedent of H If Yes, specify Cuba 1□ Yes 2\ No	Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		Race - America Black, White, on Cify: WH	
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Maryiarnd Z IZ IS-0050 of 2 should be filed within 72 hours at th and Mental Hygiene. 27 is marked other than "naturel; or traumatic event, the McCical Earn	To Be	17. Father's Name (First, Middle, La  CLARENCE TILGE	IMAN BIS	<b>БНОР</b>			]	ETHEL		LETT		
and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship FRANCES D. ROSCH			841	ng Address (Street a		D, CE	ENTREVI	. ,		•
Dallingte, Dentil Pages 1 a Department of Her mportent: If item any injury or othe		20a. Method of Disposition  1		State	cemetery, crei	osition (Name of matory or other place  T CEMETER		Da -13-2			ORO, MI	
permit. Deportruitmpc rte any inju		21. Signardina Funeral Service Lic	el feulu	n	F	2. Name and Addres ELLOWS, HE 08 S. LIB	LFENBI	EIN 8	NEWNAM	M FUNE	ERAL HO	ME, P.A.
Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	molications that c by one cause on e	aused the dea	ath. Do not ent	neumin i	g, such as c	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
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vitari reicien: T s certificate director, pa	Be	25. Was case referred to medical/ examiner?	Hospital:			Othe			Check only on			
To the Hospitel or Attending Physicien: The law within 24 butus after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	itlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date (Mont	·	28b. Time o Injury	f 28c. Injury Work	4 🔲 Nur	28	e 5 keside 3d. Describe ho			)
or Atter after dea i Director d in by the	Certification:	3 Suicide 6 Could not determine	286. Place	of Injury - At I	home, farm, str	reet, factory, office		28	8f. Location (St. City or Town	reet and Nu n. State)	mber or Rural	Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying 2 Madical Ex	aminer: On the ba	best of my kr asis of examin ner stated.	nowledge, death nation and/or in	h occurred at the tim vestigation, in my op	ne, date and pinion, death	d place, an	nd due to the ca d at the time, da	ause(s) and ate and plac	manner as sta e, and due to	ited. the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier	1-		Pu	29c. License	594	20	29	9d. Date sig	ned (Month, D	Pay, Year)
1/ 1/		30. and address o person wh			10 4 0	Print)	Av	( 0	بالمرابع المرابع	MO	216	17
Sta Registr		31. Date filed (Month, The Mear) 1		egistrar's Sign	1.5	Mand .	1100	<u> </u>	ATTO CO LEGA	7 - (1)	0416	1

State of Maryland / Department of Health and Mental Hygiene 200415846 State Registrar Amend#25,27,28perME FCHD Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month April 24,2004 Year **Physician** 9:23 A. DeCarlo Robert /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | ULY 28; Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** TO M 2 F 1916 88 199-10-1959 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County or Itams 23a or 28a-f show jiene. r than "natural", or Itams 23a or 28a-f shov Ita Madical Exertitier nast te natified #1 1⊠Yes 2 No Walkersville Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21793 U.S.A. 206 Swallow Falls Court death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □XYes 2 □ No 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or than any injury or other treumatic event, the Madical Exercitiest once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: white Specify: δ 3XXWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Coal Mines Miner 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Conchetta Difigeio Santo DeCarlo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21793 206 Swallow Falls Ct., Walkersville, Maryland Santo DeCarlo - Son 20b. Place of Disposition (Name of \_cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place LaFayette Memorial April 28. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brier Hill,Pennsylvania 2004 Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 du Pnysician 1142 Me 414 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician for use as the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetat death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ №6 page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes certificate 2 No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospitat: 1 patient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို Yes -25 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: After 1 Natural 2 X Accident 5 Pending investigation To the Hospins after death.

To the Funeral Director: Aft 1 ☐ Yes 2 X No 2:00 April 17,2004 Fell 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Rest Home 6441 Jefferson Pk Frederick,MD 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Themos 6 huston Nela. 3eruil 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2004 Registrar

		1- State Registrar Amend#20b, pe  1. Decedent's Name (First, Middle, Last)	tate of Marylar	id / Depa , <i>Cei</i>		lealth and M Death 5/6/	04 Re	g. No. 200	3. Time of Death
Physic /Medi Exami	cal	Karl Didas  4a. Facility Name (If not institution, give stree 1007 Young Place			Frederio		May 4, 2	4c. County of De	11:30 a. <sup>M</sup> ath .ck
Funeral Director		5. Social Security Number  124-26-8642  Usual Residence of Decedent	7. Age (In yrs. 70	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, April 24	9. Bi , 1934 Ne	rthplace (State or Foreign Sountry) W York
ne Marylan Ba-f show	ctor	10a State Maryland Frederick		ry, Town or Lo Freder					10d. Inside City Limits 1  Yes 2 No
3a or 2	i Dire	10e. Street and Number 1007 Young Place			10f. Zip Code 2170	)2	10	g. Citizen <i>o</i> f What C U . S . A .	country?
within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show fre Madical Eventiner must be natified at	by Funera		Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent of F f Yes, specify Cub	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
be filed within 72 hould Hygiene. Id other than "naturionent, the Medical Covent, the Medical Covent, the Medical Covent, the Medical Covent, the Medical Covent, the Medical Covent, the Medical Covent, the Medical Covent	Completed by Funeral Director	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12) 12	on ompleted) College (1-4or 5+)		lent's Usual Occup kind of work done DO NOT use retire	pation during most of worki d)		6b. Kind of Business	s/Industry
Men	To Be C	17. Father's Name (First, Middle, Last) John F. Didas			944601	18. Mother's Name Ruth Sw		aiden Sumame)	
permit. Pages 1 and 2 sho Department of Health and 1 Important: If tiem 271s ma any injury or other traums once.		19a. Informant's Name/Relationship (Type, Catherine Didas — w 20a. Method of Disposition  1	ife 20b. F	1007 Place of Disponentery, creme e Grove	Young Esition (Name of natory or other place Cemeter  Name and Addre	(ce) 5/7/7 y 4/1/	derick, leading of the derick of the deri	Maryland C. Location - City of t. Airy, Funeral H	21702 Town, State Maryland
Physician //Medical Examiner  Assignment of the privilent	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence to (or as a consequence)	uence of):	ijoza	thy			Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
w requires that been signed b should be deta	by	Part II. Other significant conditions contrib	uting to death but not resi	ulting in the un	derlying cause giv	ren in Part I.			o the cause of death?
	Completed	Hyperfen Diabet	sion				24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Attending Physician: Trideath, rideath, ector: After this certification the funeral director, pa	ation: To Be	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	ital: 1  Inpatient 2  Isa. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	y at 2		ce 6 Dother (Spe	cify)
ital or Attenurs after deat ral Director: lled in by the	Certification;	4   Homicide	8e. Place of Injury - At he building, etc. (Specify	v)			City or Town,		
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physicia (Check only one) 29b. Signature and title of certifier	en: To the best of my kno On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tinestigation, in my o	pinion, death occurre	ed at the time, date	se(s) and manner as and place, and due . Date signed (Mont	to the cause(s)
		30. Name and address of person who compl	eted cause of death (Item	1 23а) (Туре, Г	DOC	57362		May 6	, 2004
Sta	ite ar	Jean R. Hou M 31. Date filed (Month, Day, Year)	D ZO40 32. Registrar's Signa	7 Se	neca M	1eadows	PKWY	, Germa	antown, M 20876

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 5:30 AM MAY 10, 2004 ROBERT CLARENCE EIKER /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number, Examiner **EMMITSBURG** FREDERICK 116 S. SETON AVE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) JAN. 21,1917 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1⊠M 2□F EMMITSBURG, MD Director 220-10-5791 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo MARYLAND FREDERICK **EMMITSBURG** 10g. Citizen of What Country? 10e Street and Number 10f Zin Code U. S. A. Itams 23a Funeral 116 S. SETON AVE. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritat Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Itan any injury or other traumatic event, the Medical Exam par once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHTTE ρ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) CONSTRUCTION CARPENTER 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LAURA VAN SICKLE FRANCIS EIKER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21120 MARTINSBURG RD, DICKERSON, MD. 20842 DOROTHY FOX/ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State EMMITSBURG MEMORIAL, 1 4 ☐ Donation 5 ☐ Other (Specify) 5/13/04 EMMITSBURG, MD. 21727 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., thin EMMITSBURG, MD. 21727-0427 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if on, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pheumoni davs /Medical Due to (or as a consequence of): Examiner congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Coconar and Due to (or as a consequence of attending physician Box 68760 Physician/Medical ardiac as the esn Jo 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.0 the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 certificate has autopsy 2X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 1 Yes 2√2 No 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 determined 4 - Homicide filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tittle of certified MAY 10, 2004 30. Name and address of person who completed cause of death (It in 3 a) (Type, Print) ur lev MD Main St. Christine 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 1 8 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Dey Month Year **Physician** Jack Elliott ECIBONE May 2004 5:23 P.M. /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Julia Manor Health Care Center Hagerstown Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) if Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□ F Yrs. Director 216-14-6455 80 28 1924 Feb. Maryland Usuel Residence of Decedent with the Merylend 10a. Stete Pages 1 and 2 should be filed within 72 nouses....
ment of Health end Mental Hygiene.
fant: If item 27 is marked other than "naturel, or items 23s or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funerai 21740 33 Elizabeth Street U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: δ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Truck Driver City Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ezichelle Ecibone Laura Elliott 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John Sagle</u> P.O. Box 298 Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State W Burial 2 ☐ Cremetion 3 ☐ Removal from State Department o important: If i eny injury or once. 4 Donation 5 Dother (Specify) Rose Hill Cemetery 5/4/04 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical B cell Lymphoma approx.1 mo Examiner Due to (or as a consequence of): Examiner physician and the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) for use as Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' certificate has b lirector, page 2 s 1□ Ves 2℃No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this Ucompletely filled in by the funeral 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted. Medicai (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Yeer) 1) 52327 346 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Dr. Khalid Waseem 1126 Opal Court Hagerstown, Maryland 21740 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State MAY 0 4 2004 Registrar

DAP			1 - For State Registrar		State o	of Maryla	nd / Dep		t of H	ealth and			C 0 0 4	1585	0
	Physici /Medic Examir	cal	Decedent's Name (First, Charles     4a. Facility Name (If not ins WASHINGTON CX	titution, give :	Leo street and nu		F	risby <sup>4b.</sup> City, HAGE	Town, or	Location of De	APR	of Death	Day Year , 2004 4c. County of Death WASHINGTO		M
	. Funeral Director		5. Social Security Number 162–48–1053		M 2□F	7. Age (In yrs	7 Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	in. 8. Date (Mon	of Birth th, Day, Yea 16,195	9. Birth Coo Mary	place (State or Fore intry) land	nign
	the Maryland 28e-f show	ector	Usual Residence of Decede  10a. State 10b. C  MD Wa  10e. Street and Number		on		ity, Town or L	own						10d. Inside City Lin 1 \overline{\text{Y}} Yes 2 □	
	h with 1	al Dir	420 Mitchell	Ave.				10f. Zip	Code 1740				Citizen of What Cou	intry?	
Baltimore. Maryland 21215-0036	within 72 hours after death with the Maryland ene. hen "natural" or items 23a or 28e-f show re Madical Examinar must be notified at	d by Funeral Director	11. Marital Status  1 □ Never Married 20  3 □ Widowed 4 □ Div	Married	Armed Fo	2□No 19	7.	Was Deced If Yes, spec		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes erto Rican, et		14. Race - Amer Black, White	, etc.	
15-(	in 72 hours "natural", Redical Ex	oletec	(Specify only		completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ition uring most of w	vorking	16b.	Kind of Business/Ir	ndustry	
212	filed with Hygiene. other the	Completed	Elementary/Secondary (0		College (1	I-4or 5+)	Carpe					Ac	lvanced T	echnology	
and	d be fill ental Hy ted oth	To Be	17. Father's Name (First, M Charles Leo		, C.					18. Mother's N		iddle, Maide	en Sumame)		
2	2 should and Men Is marke aumatic		19a. Informant's Name/Rela	ationship (Ty)	oe, Print)		19b. Maili	ng Address	(Street a	Elaine		lumber, City	or Town, State, Zij	o Code)	
<u>≥</u> نه	1 and 1 Health Health ther tr		Donna K. Sund	ler1and	1/Wife	20b.	420 Mitchell Ave. Hagerstown  20b. Place of Disposition (Name of commetery, crematory or other place)  Date							Ctata	
	Pages nent of int: If it		1 XBurial 2 ☐ Crema		emoval from	_							Location - City or T		
Balti	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event. It a Mones.		*4 Donation 5 Other (Specify)  Rest Haven Cemetery 5/3/2004 Hagerstown MD  1. Signature of Funeral Service Licensee  22. Name and Address of Facility Rest Haven Funeral Chapel												
	- i-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betweet Onset and Death.												
8760,	Physician / Medical Examiner but sician and but sician and the pruial-transit	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			or as a consector as a consector as a consector	quence of):		756	leste	Cool	own L	l. Vrse.		
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ital Records,		Completed										Was an autopsy performed? es 2 □ N	prior to con death?	psy findings availab npletion of cause of 2 No	le
W.5	> .9 P	To Be	25. Was case referred to me examiner? 1 X Yes 2 ☐ No	<del> </del>	ospital:	npatient 2	ER/Outpatien	t 3 DO	Other	26. Place of De		111000	6 ☐Other (Specifi	()	-
Division of	ding h. After fune	Certification:	27. Manner of Death  → Chatural  □ Pending □ Accident  □ Suicide  □ Could not be  □ Could not be					М			28d. Desc	ibe how inju	iry occurred		
Divi	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.		4  Homicide de	etermined	buildin	of Injury - At hing, etc. (Specif	y) 				City of	Town, Stat			
		edical	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Physi fical Examin	ician: To the er: On the ba and mann	isis of examina	wledge, death ition and/or inv	occurred a restigation, i	t the time in my opii	, date and place nion, death occ	e, and due to curred at the ti	the cause(s me, date an	) and manner as st d place, and due to	ated. the cause(s)	
	To the law within 2 To the law complet	ž	29b. Signature and title of ce	ertifier	4/6	TX		29c.	License	ocmE		1	te signed <i>(Month, I</i> L 29,2004		,
_	Cation		30. Name and address of pe	rson who con	npleted cause	death (Item			n St	reet, E	Baltimo	re, M	aryland 2	1201	
	Stat Registra		31. Date filed (Month APR	30 20	U4 32. R	gistrar's Signa		rede							

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

					,	Cert	ificate of	Death	,	Reg. No. 2	004	15851
	Discosioni		1. Decedent's Name (First, Mide	dle, Last)					2. Date of De	ath Day	Year	3. Time of Death
N. W. W.	Physici /Medio		Jay Ambrose					4h City Tayon a	April Location of Death	30 200	04	7:50 a.m.
4	Examir	er	4a Facility Name (If not instituti								ty of Death	
			Williamsport  5. Social Security Number		ge (In yrs. la	et hidhdayl	If Under 1 Year	William	sport  s. 8. Date of Bir	Wash	ingto	
	Funeral Director		212-38-9258 Usual Residence of Decedent	1⊠ M 2□ F	92	Yrs.	Months Days	Hours Mir	June 28	iy, Year)		place (State or Foreign ntry) ine
	yland		10a. State 10b. Count	у	10c. City,	, Town or Loca	ation					10d. Inside City Limits
	Marfat a-fat	ţo	Marvland Wash	ington	W	illiam	sport					1X□Yes 2□No
	्रे कि कि	- Je	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
	23e	Funeral Director	Milestone Gard				217	95		U.S.		
	terms	une	11. Marital Status	12. Was Decedent Armed Forces	?	5. 13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ice - Americ ack, White,	
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Ma 3 M Widowed 4 Divorce	If Yes, Give		-46 <sup>1[</sup>	□Yes 2∏ No	Specify:		Speci	ty: Wh	ite
5	natu	ete		nt's Education est grade completed)		16a. Decede (Give ki	nt's Usual Occur ind of work done	pation during most of wi d)	orking	16b. Kind of E	łusiness/In	dustry
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d 2	Hygie Hygie off.		12 17. Father's Name (First, Middle			ре	ncist	18. Mother's Na	ame (First, Middle,			
an	Id be ental ked o	To Be	Solomon Fairch	nild				Marv	Blee		,	
Maryland	2 should be i end Mental is marked of aumatic eve		19a. informant's Name/Relation			19b. Mailing	Addrass (Street		Rural Route Numbe	er, City or Town	ı, State, Ziç	o Code)
Σ	end 2 seith e n 27 is		Katrina Everso	le State H	Exec.	17312	Amber	Drive H	agerstow	n. Md.	21740	
J.e.	of Heelth of Heelth of Item 27 is		20a. Method of Disposition		20b. Pla	ace of Disposi	tion (Name of atory or other pla		Date	20c. Location		
Ē	nit. Pages ertment of } ortant: If its injury or of		1 ⚠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (			lest Ha	ven Cem	etery	5/4/04	Hagerst	own,	Maryland
Baltimore,	permit. Page Depertment Important: any injury once.		21. Signature of Funeral Service	Licensee			Name and Addre		Minnich			
ш	205 2 3		Walnut	Klark	in	41.	5 E. W13	lson blv	l. Hagers	stown, 1	faryl:	and 21740
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause of only one cause on each l	d the death. ine.	Do not enter	the mode of dyi	ng, such as cardia	ac or respiratory as	rrest,		Approximate Interval Between
	Physician		I Company									Onset and Death
<b>A</b>	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Preu	moni	a						3 days
		-			Due to (or	as a consequ	ence of):					,
	d d ansit	Examiner	Coguantially list conditions	<b>b</b>	Due to (or	as a conseque	ance of):				-	
ó	law requires that the death certificate be executed as been signed by the attending physician end 2 2 should be detached for use as the buniel-transit	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	]	200 10 (0.	ao a somooqu	31.00 31,1					
68760,	ate be nysici he bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a	as a conseque	ence of):					
39	ertifica ling ph	Mec	,	L							ļ	
Вох	eath ce attendii for use	lan/		d								
	t the dea	ysic	Part II. Other significant condit	ions contributing to death b	out not result	ting in the und	lerlying cause giv	ven in Part I.	23b. Did 1	obacco use co	ontribute to	o the cause of death?
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of Vital Records,	uires sign ld be	d D							24a. Was	an autopsy	24b. W	ere autopsy findings
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tal	In: T	BeC	25. Was case referred to medic		aen			26. Place of De	eath (Check only o		1	
	Physician: this certific rel director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2□E	R/Outpatient	3□ DOA Oth		Home 5 ☐ Resid		her (Specif	(v)
0			27. Manner of Death  1 ☑Natural 5 ☐ Pendi	28a. Date of Inju	iry iy Year) 2	28b. Time of Injury	28c. Inju		28d. Describe I			
Sio	Attending or death.  actor: After by the fune	catic	2 Accident invest	igation			M 1□	Yes 2 □ No				
Division	or Att after d Direct J in by	Certification:	4 Homicide deter	nined 200. Flace of III	jury - At hon ic. <i>(Specify)</i>	ne, farm, stree	t, factory, office		28f. Location (S City or Tox	Street and Numi vn, State)	ber or Rura	al Route Number,
	pltal ours a orai D	2	29a. Certifier 1 Certifyi	na Phyeloien: To the hest	of my knowl	ledge death o	occurred at the ti	mo data and plan	a and due to the	naugo(a) and m		aread .
	To the Hospital or Att within 24 hours after d Jo the Funeral Direct completely filled in by	edical	(Check only one)	ng Physician: To the best Examiner: On the basis of and manner st	f examination	on and/or inve	stigation, in my o	pinion, death occ	urred at the time,	date and place,	and due to	the cause(s)
	Nithin Nithin Fo the	M	29b. Signature and title of certifi	er			29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	To the within 2.		conthi	Kuttre	-San	nds me	D	47451	1	April 3	0,20	04
	gxi	ŀ	30. Name and address of persor	who completed cause of o	leath (Item 2	23a) (Type, Pr	rint)	^	2/ /5	Y North	Art	Day, Year) 204 -13an Street Xangland
				er-Sands M	D. W	illiams	Sport A	lursing	40me w	Mamso	ort. 1	Kansland
7	Sta	te	Synth, a Kuthn 31. Date filed (Month, Day, Year	1 2004 32. Haristi	ar's Signatu	ire /	. #				1	1
	Registr	ar	rini V	7 4UU4 ABAR	un 1	J. Sin	and I					

			1 – For Registrar	State of Ma	arylan				ealth a Death	and M		giene Jeg. No.2	004	15852
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea	th		3. Time of Death
	Physici		Juanita	Love			Fox				Month May	Day 1	2004	10:10 P <sup>M</sup>
}	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location of	of Death			nty of Death	10.10 1
		•	17711 Timber Lane				Hage	rsto	wn			Was	hingto	n
	Funeral		5. Social Security Number 6. Sex		e (In yrs. i	last birthday)	If Under	r 1 Year	If Under		8. Date of Birth	1	9. Birthp	lace (State or Foreign
	Director		230-24-2004	M 2X)F	77	Yrs.	Months	Days	Hours	Min.	Oct. 15	,1926	Virg	inia
	Ŋ.		Usual Residence of Decedent											
	show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	e Ma	cto	MD Washingto	on	Hage	erstown	1							1 ☐ Yes 2 No
	ith th	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cour	ntry?
	23a	a	17711 Timber Lane				2	1740				U.S.	Α.	
	r deg	ne	11: Marital Olatos	12. Was Decedent Armed Forces?		S. 13. V	Vas Dece	dent of Hi cify Cuba	spanic Orig	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
98	s afte	by Funeral	1 □ Never Married 2 → Married	1 ☐ Yes 2 🔀	No	1	□Yes	2 <b>☑</b> No	Specify:				<sup>cify:</sup> Whit	
8	ureľ ureľ	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10: 5								
<u> </u>	be filed within 72 hours after death with the Maryland all bygiene. All bygiene do they than "neturel", or teams 23a or 28a-f show do ther than "neturel", or teams 23a or 28a-f show event. Its Maulical Exartains must be notified at	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced		rk doné d	lurina most	of worki	ing	16b. Kind o	Business/In	dustry
7	within	Ę	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homen		se reureu,	,			D	4	
2	Hygir Ther Int.	ပိ	17. Father's Name (First, Middle, Last)			Homen	aker		18 Mothe	r's Name	(First, Middle, i	Domes		
an	d be intal	<b>B</b>	Robert H. Brill									raidon con	amo)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Maralal Hygiens. Department of Health and Maralal Hygiens. Described it if item 23 a or 28s f show importent: it item 23 a or 28s f show eny injury or other traumatic event. Ite Marylical Examinational Le notified at once.	မှ	19a. Informant's Name/Relationship (Type	ne Print)		19h Mailin	n Address	(Street a			arrick U Route Number	City or Tou	un Stata Zin	Code
₹	d 2 s th an 17 ls i		Willis C. Fox/Husba	•		1.					rstown,			Code)
ď.	1 an Healt em 2		20a. Method of Disposition		20b. P	lace of Dispos			Lane 1		-		.1740 n - City or To	wn State
Baltimore,	ages of of or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	_ C6	emetery, cren	natory or o	ther place						
ij	t. Pč rtmer rtent njury		'4 ☐ Donation 5 ☐ Other (Specify)		Res	t Have			ry  5,	/5/2	004	Hager	stown,	MD
Ba	Depa Impo eny is		21. Signature of Funeral Service License	'		1.6	. Name an	na Adares	s of Facility	Res	t Haven	Funer	al Cha	pel
	1010 G		sight for the	Sup	4 41 1						ve. Hage		n, MD	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each li	ne.	. Do not ente	er the mod	ie ot dying	g, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death,
8	Physician		Immediate Cause (Final disease or condition		6	e Mus		Con	ce					10 month.
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):								
	LXdiiiiiici	_	Sequentially list conditions, if any, leading to immediate											
	pe ji	in a	frany, leading to immediate cause. Enter Underlying Cause (Cause Cause) that initiated events	Due to (or as	a consequ	dence of):								
	and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as	2 0000000	iance of):							-	
8760,	cian cian buria	E		D00 10 (01 03	a consequ	abrice dr).								
87	The law requires that the death certificate be executed tale has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d											
9 ×	leath certific attending p	by Physician/Me	IF FEMALE:	Sc. if yes, outcome	of pregna	nev	_							
Вох	atten for u	jan	in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetal	death 3□	Ectopic pr						Date of delive Month	ry Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown	unie oi de	aui 5	Other (sp	ecity)						
۵.	that the de led by the a detached f	F.	Part II. Other significant conditions con	tributing to death b	ut not resu	ulting in the un	derlying c	ause dive	n in Part I		23e Did tob	nacco use co	ontribute to th	e cause of death?
Records,	ires tha signed d be det	d b		3		•	,					s 2⊡No		ably 4 □Unknown
0	w require been signature should b	Completed												
ec Sec	e law has l	du									24a. Was a autops perform	n 241 y	o. Were autor prior to con	osy findings available appletion of cause of
<u> </u>	: The l cate ha										1 Yes 2		death? 1 🗆 Yes	2 🗆 No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:				000		of Death	(Check only on	e)		
5	Physi this c	ို	TES ZEZINO	1 Linpatie		ER/Outpatient		1	4 🗆 Nui	-	ne 5 Afeside			)
Ē	ding F h. After funer	Ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry y Year)	28b. Time of Injury		8c. injury Work	?		28d. Describe ho	w injury occ	urred	
Division of	tend leath tor: ,	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		es 2□N					
$\geq$	or At after of Direct in by	E	4 Homicide determined	28e. Place of Inju- building, etc	ury - At ho c. <i>(Specify</i>	me, farm, stre	et, factory	, office		2	28f. Location (St. City or Town	reet and Nui , State)	nber or Rurai	Route Number,
니	To the Hospitel or Attending Physicien: within 24 hours after death as a fire death To the Funeral Director: After this certifica completely filled in by the funeral director; to		On Continue All de la la la la la la la la la la la la la	lalas T. d. i	-6 1	.dada				- 1	-11			
	Hosi 24 ho Fun Fun tely f	ica	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	er: On the basis of	examinat	wledge, death ion and/or inv	occurred estigation,	at the time , in my op	e, date and inion, deatl	i place, a h occurre	and due to the ca and at the time, da	iuse(s) and i ate and placi	manner as sta e, and due to	ated. the cause(s)
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	one) 29b. Signature and title of certifier	and manner sta	1180.		290	. License	number		20	nd Date eige	ned (Month, L	Day Year
	¥ ¥ ₹ 8	-	Do 1	Dag 1	,	4 1	230	1 .			-			
			Muchuel f.	Markon		mo		114	166	7		5 .	3.0	4
1-1	YU		30. Name and address of person who con	•				^	1		. 1	1	3.0	1. 0
1			31. Date filed (Months Bank Year)	32. Registra		110 /	<u>ved</u>	1221	Ca	m.	2 /tz	900/0	m /	NU.
	Sta Registr		MAT U'3 20	14 Janes	ار مد	6. Ap	تبطوا	•						

			State of Maryland / De	partment of Health and M	-	
			101	ertificate of Death	, ,	No2004 15853
	Physici	20	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Yeer 3. Time of Death
	/Medic	al	William Lewis Fischer, Sr.		April.	28-2004 6:15 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Ye	Washington  9. Birthplace (State or Foreign Country)
	Director		219-20-2978 <sup>1</sup> \(\text{\text{\$\exitt{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\etitt{\$\tex{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\}}}}\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\tex	Months Days Hours Min.	Dec. 22	1927 Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary 9-f sh	tor	Maryland Washington Ha	gerstown		1 ☐ Yes 2 🌠 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23a		12227 West Lawn Lane	21740		U.S.A.
10	Iter de	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ X Yes 2 □ No	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I</li> </ol>	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show Josel Evanti set must be profitted at	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: W.W. II	1 ☐ Yes 2 X No Specify:		Specify: White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any figury or other traumatic event, the Maclosal Examination and once.	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired)	ng 16b	. Kind of Business/Industry
121	within ene. then	ошо	Elementary/Secondary (0-12) College (1-4or 5+)			Food
קפר	e filed il Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)	ruck Driver 18. Mother's Name	(First, Middle, Maid	
ylar	Menta Menta arked	To E	Louis Walter Fischer	Julia An	n Ambrose	
Nar	12 shound and 7 Is muraum.			illing Address (Street and Number or Rura		
	1 and Healtl em 27		Grace Fischer - Wife 122 20a. Method of Disposition 20b. Place of Dis	27 West Lawn Lane position (Name of Drematory or other place)		m. Md. 21740 Location - City or Town, State
Baltimore,	Pages ent of ht: If it ry or c		1 Abunar 2 Clemation 3 Demoval from State	rematory or other place) wn Mem. Park   5/1/0		
altii	permit. I Departm Importer Iny inju		Occur Ea			gerstown, Maryland eral Home
<u> </u>	8858		James K. Spicer	415 E. Wilson Blvd.		
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	r respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ma		days
ř.	Examiner		Due to (or ) a consequence of):	Renal Failure.		manth 5
	D =	ner	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Oue to (or as a cor sequence of):  Concestive  c.	Renal Failure deast failure		
	be executed ician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as consequence of):	deant tailure		months
760,	ate be executed hysician and the burial-transit	cai E	Sue to (di est consequence di).			
99	tificate ig phys		0.			
Box	death certifica e attending ph of for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery
0	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med		Other (specify)		Month Day Year
Δ.	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	w requires been sign should be	ed by			1 🗆 Yes	2 No 3 Probably 4 Junknown
Records,	The law requires that the ate has been signed by the bage 2 should be detached.	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
-		Соп			performed	death?
Vital	sicien: Th certificate irector, pag	o Be	25. Was case referred o medical examiner?  1   Yes   2   No   Hospital: 1   Impalient   2   TER/Outnati	26. Place of Death		
10	Attending Physicien: r death. ector: After this certifici by the funeral director,	<b>—</b>	27. Mann of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	e 5 ☐ Residence 8d. Describe how in	6 ☐ Other (Specify) jury occurred
Sior	endin sath. or: Aft he fur	atio	2 Accident investigation	Work? M 1 □ Yes 2 □ No		
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	spitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de-	ath occurred at the time, date and place, a	nd due to the cause	(s) and manner as stated
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examiner: On the basic of examination and/or and profes state).	investigation, in my opinion, death occurre	d at the time, date a	and place, and due to the cause(s)
	With Com	Σ	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	A>			1110052136		24/29/2004
	51.		30. Name and a fress of person who completed cause of death (Item 23a) (Type Dr Ciccare III 3 Byrkt	MD0052136 Drive William	sport V	Waryland
	Sta					
	Registr	ar	31. Date filed (Mohlti, Day, Year)  APR 3 0 2004  32. April 1 2004	MAKE		

18.0	an		1. Decedent's Name (First, Middle, Last)  JANETTE CORNISH GERVIN							Year	Time of Deat
/Medio		4a. Facility Name (If not institution,	4b. City, Tox	wn, or Location	on of Death	MAY		nty of Death	34P.		
		528 BROADCREEK	DRIVE			NSVILI			QUEE	N ANNE	
Funeral Director		153-40-7336	6. Sex 1 □ M 2  F	7. Age (In yrs. last birtho	Months D	Year If Und Days Hour	der 24 Hrs. rs Min.	8. Date of B (Month, I	lirth Day, Year) • 1947	9. Birthplace Country) NEW JE	(State or Fore
M II		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location					10d.	nside City Lim
r 28e-f show	ţō	MD QUEEN	ANNE'S	STEVENS	SVILLE						I □ Yes 2 📉
ims 23a or 28e-f show ir must be notified at	Director	10e. Street and Number			10f. Zip Co	ode			10g. Citizen o	of What Country?	
23a (		528 BROADCREEK	DRIVE		2166	66			USA		
ral', or Items Examiner m	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Ford	2 <b>X</b> No	13. Was Decedent If Yes, specify 1 Tyes 2			ecify Yes or N Rican, etc.)	lo- 14. R B	lace - American I llack, White, etc. cify: WHIT	
jiene. ir then "netural", or Ite Die Medical Examine	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	t grade completed)  College (1-	4or 5+)	ecedent's Usual O Give kind of work d fe. DO NOT use n	lone durina n	nost of work	ing		Business/Industr	у
		12 17. Father's Name (First, Middle, L	5+	PHY	YSICIST	18 Mc	athor's Nam	o /Eirst Middle	SCIEN e, Maiden Surn		
ev ev	To Be	CHARLES GERVIN				MA	RJORII	E CORNI	SH		
of Health and Mer item 27 Is marke r other traumatic		19a. Informant's Name/Relationsh LILLIE LUONGO/S			MINOT AV				ber, City or Tow <b>720</b>	m, State, Zip Cod	(e)
°= 5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from S	20b. Place of D. cemetery.	isposition (Name of crematory of other GARET S	of r place)		Date	20c. Location	n - City or Town,	State
ortent: injury	1	'4 □Donation 5 □ Other (Sp.		CHURCH	CEMETERY			/2004	ANNAPO	LIS, MD	
permit. Pag Department Importent: any injury o		21. Significate of Funeral Service L	icensee /		22. Name and A	ddress of Fa	cility	E NEW	INITE MAN	ERAL HOM	E DA
iysician Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a///	N	enter the mode of c ket c	IROCK 1	RD., C	HESTER	, MD 2	1619 App	roximate rval Between set and Death
Medical xaminer privial-transit	cal Examiner	disease or condition	a. Due to (o	used the death. Do not ch line. Diab ti	enter the mode of C keto c	IROCK 1	RD., C	HESTER	, MD 2	1619 App	roximate rval Between
Medical  Amana and and lor use as the burial-transit	dlcal	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (o b. Due to (o c. Due to (o d	used the death. Do not chine. Diabeti or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of):	enter the mode of C keto c	idosis	RD., C	HESTER	arrest,	1619 App	roximate rval Between
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ate has been signed by the attending physician and multiple and page 2 should be detached for use as the buriat-transit	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outcome to be a contributing to dea	used the death. Do not ch line. Diabeti or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of): or as a consequence of):	anter the mode of c keto c keto c	ancy e given in Par	as cardiac of Death	23e. Did 1 24a. Wasaute perf 1 Yes	23d. D Notobacco use con Yes 2 No s an psy 2 No one	Appline Ons Application Ons Application Ons Application Ons Application Ons Application Ons Application Ons Application Ons Application Ons Appline Ons Application Ons Application Ons Application Ons Applicatio	Year  4 Unkno
fler this certificate has been signed by the attending physician and moral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1 □ Yes 2 □ No  27. Manner of Death 1 □ latural 5 □ Pending investigal 2 □ Accident 3 □ Suicide 6 □ Could not	a. Due to (o b. Due to (o c. Due to (o d. Due to (o d. Pregnai 9 Unknow  Hospital: 1 Ing 28a. Date of (Month, ation of be	used the death. Do not chine. Diabeti  or as a consequence of):  or as	enter the mode of c keton c keton c s leave to c leave	ancy y) e given in Par  26. Pla Other: 4 linjury at Work? 1   Yes 2	as cardiac of Seath Nursing Hol	23e. Did 1 □ 24a. Was auto perf 17 Yes heck on me 5 □ Res 28d. Describe	23d. D N v tobacco use core yes 2 No san psy ormed? 2 No one idence 6 Xot how injury occur	Date of delivery Month Day  Tribute to the car  3 Probably  Were autopsy fi prior to complet death?  Yes 2   ther (Specify) So	Year  4 Unkno
fler this certificate has been signed by the attending physician and moral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (o b. Due to (o c. Due to (o d. Due to (o d. Pregnai 9 Unknow as contributing to dea hospital: 1 Ing 28a. Date of (Month, ot be ned 28e. Place of building	used the death. Do not ch line. Diabeti  or as a consequence of):  or	all Ectopic pregn. C Retoric  Sectopic pregn. C Other (specif) e underlying cause tient 3 DOA e of 28c. I	ancy  e given in Par  Cher: 4  Unjury at Work? 1  Injury at Work? 1  Injury at Work? 1	as cardiac of Death Nursing Ho	23e. Did 1 1 24a. Wata auto perf 12 Yes n heck on me 5 Res 28d. Describe 28f. Location City or To	23d. D  tobacco use cor  Yes 2 No s an 24b. ppsy ormed? 2 No one idence 6 Not how injury occu  Street and Num wm. State)	Appline Ons  Date of delivery Anoth Day  Intribute to the car  3 Probably  Were autopsy fi prior to complet death?  Types 2 United  The (Specify) Sourced	Year  4 Unkno  Indings availa  on of cause of No
fler this certificate has been signed by the attending physician and moral director, page 2 should be detached for use as the burial-transit	ledical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1   Yes   2 No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes   2   No 27. Manner of Death   No   No   No   28. Manual   No   No   No   No   29. Accident   No   No   No   No   3   Suicide   Gould no   Getermine   29a. Certifier   Check only   One)   Medical Example   29a. Certifier   Check only   One)   Medical Example   29a. Certifier   Check only   One)   Medical Example   29b.   Medical Example   Medical Example   20b.   Medica	a. Due to (o b. Due to (o c. Due to (o d. Due to (o d. Pregnar 9 Unknow  Inscontributing to dea A Date of (Month, ation of the 28e. Place o building	used the death. Do not ch line. Diabeti  or as a consequence of):  or	anter the mode of cketor cketor cketor cketor c	ancy  26. Pla  Other: 4  Injury at Work?  1 Tyes 2 inceeding opinion, date my opinion, date	as cardiac of as cardiac of Death Nursing Holiace of Death and place, a eath occurred	23e. Did 1  24a. Was autopent 17 Yes 1 heck on the 5 Res 28d. Describe 28f. Location of City or To	23d. D  tobacco use cor  Yes 2 No  san psy ormed? 2 No one idence 6 Not how injury occu  Street and Num wn, State)	Date of delivery Month Day  Tribute to the car  3 Probably  Were autopsy fi prior to complet death?  Yes 2   ther (Specify) Sourced	Year  year  4 Unkno  ndings availa on of cause of
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State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Dennis Wayn May 0636 M eous 2004 /Medical 4a. Facility Name (If not institution, Give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** Hagat Slaw.

If Under 1 Year If Under 24 Hrs.

State | Days | Hours | Min. Lorraine (Nas) 19520 TETTACE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□F Yrs. Director 53 217-56-2390 15, 1950 June Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19520 Lorraine Terrace 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Liquor Store Owner permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold A. Gigeous Juanita Ashby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra K. Gigeous - Wife 19520 Lorraine Terrace Haverstown, Md. 21740 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 5-5-04 Hagerstown, Maryland 2. Name and Address of Facility 21. Signature of Furieral Service Licensee Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Laknown /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and physician ar s the burial-t Due to (or as a consequence of): Box 68760. Physician/Medicai as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Year 5 ☐ Other (specify) P.O. ed by the e 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 4 Unknown as been si 1 □ Yes 2 □ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed2 page certificate 2 No 2 No 1 Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending within 24 hours after death.

To the Funeral Director: Af М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 56826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ans rams 20311 Lappans Rd. Suite 103 31. Date filed (Month, Day, 32. Registrar's Signature Boonsboro, Maryland 21713 Registrar

			1 - State of I	Maryland / Dep <i>Ce</i>	artment of I	Health and I Death	Mental Hygid	ene 200	15856	
B	Physici		Decedent's Name (First, Middle, Last)     Richard Gracie				2. Date of Death Month May	03 2001	3. Time of Death 12:00 p.M	
	/Medio Examir	150	4e. Facility Name (If not institution, give street and numb Sacred Heart Hospital	er)		or Location of Death	-	4c. County of Dee	eth .	
	Funeral Director		217-10-5881 1 X 2 F	Age (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 04-19-19	(ear) 9. Bi	rthpface (State or Foreign Jountry) aryland	
	the Maryland 28a-f show	Director	Usuaf Residence of Decedent  10a. State 10b. County  MD Allegany  10e. Street and Number	10c. City, Town or L			100	p. Citizen of What C	10d. Inside City Limits 1 Tyes 2 No	
	th with 23s or		19419 Lower Consol Road	d, NW		532	103	USA	outing .	
21215-0036	s within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-1 show tree manual the moulies at the Markes Examines must be notilied at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Deceded Arreed Formation of the Secondary of the Seconda	No ss: WW   1  16a. Dece (Give iife.	Was Decedent of If Yes, specify Cub  1 Yes 2 No  addent's Usual Occup  a kind of work done  DO NOT use retire	Specify:  pation during most of wor	16	14. Race - Am Black, Whi Specify: bb. Kind of Business ; Bakery	White	
Maryland 2	al Hyg 1 othe vent,	Be	17. Father's Name (First, Middle, Last)  Robert Gracie				ne (First, Middle, Ma a Parker			
aryl	2 should be and Mental is marked o	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street		ral Route Number, C	City or Town, State,	Zip Code)	
Baltimore, N	permit. Pages 1 and 2 should to Department of Health and Ment Important: If item 27 is marked any injury or other traumatic e once.		Loretta Gracie, Spouse  20a. Method of Disposition  1	20b. Place of Disp cemetery, cre Rest Lay Gardens	osition (Name of smatory or other plane)  NN Memor  2. Name and Addre	rial 05/	Date 20	c. Location - City of LaVale neral Hon	Maryland ne	
/Medica Examine	Department of the property of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cleases of higher that initiated events c.	ration Pneumas a consequence of):  as a consequence of):  as a consequence of):	monia				6 Hours	
.O. Box 6	death certifi e attending   od for use as	Physician/Med		n 2 ☐ Fetal death 3 ( t at time of death 5 (	□Ectopic pregnance □ Other (specify)	у		23d. Date of de Month	ofivery Day Year	
Δ.	signed d be de	ρ	Part II. Other significant conditions contributing to deat  Large left cerebral infarc	-	, , , , , , ,			v	o the cause of death?	
of Vital Records,	The law requate has been page 2 shoul	Completed	tumor surgery; ischemic right leg	small vesse	l disease	of the	24a. Was an autopsy performa	prior to	utopsy findings available completion of cause of	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		Ott	OF	th (Check only one)			
on of	ding h. After funei	tlon: To	1 Yes 2 No Hospital: 1 No.  27. Magner of Death 1 Notural 5 Pending 2 Accident investigation		28b. Time of 28c. Injury at 28d. Describe how injury occurred					
Division	el or Attends after death	27. Manner of Death    Actival   State							ural Route Number,	
	To the Hospitel or At within 24 hours after of To the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the besiden and manner and manner.	s of examination and/or in	th occurred at the time	me, date and place, ppinion, death occur	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)	
0	2/11/1	M	29b. Signature and title of certifier.		29c. Licens			Date signed (Mont		
	DIVA		30. Name and address of person who completed cause of	of death (Item 23a) (Type	Print)	5638		May 4, 20		
	NKS Sta	te		10701 New			a., Frosti	ourg, MD	21532	
6.	Regist		5 5 5 5 7 m	va &	Sports	,				

Registrar

ORIGINAL

Amend Ttem #28a per me (1832) Department of Health and Mental Hygiene

jorte	-	-	470
b	R	5	8

	DAP		1 - For Amend I tem #	State of M.	aryland De 12,6832,C	partment of heart of entificate of	lealth and N <i>Death 06/</i>	/lental Hyg 25/04DH	giene 89. No. 2004	15858			
-	Physici	an /	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	nth Day Year	3. Time of Death			
	/Media	cal	Jane  4a. Facility Name (If not institution, give		n Hoffman	4b. City. Town, o	r Location of Death	APRIL 2	29,2004 4c. County of Deat	11:00p M			
	Examir	ier	80 PARK LANE	,		ELKTO			CECIL				
	Funeral		5. Social Security Number 6. Sec	יין מעוד	e (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year) Co	hplace (State or Foreign			
	Director		176-26-6130 'L	7	2 Yrs.			SEPT 22,	1931 Per	nsylvania			
	rytand how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits			
	he Ma 8a-f	Director	Maryland Cecil		Elkton	т-		·		1 ☐ Yes 2 No			
	with t	Dir	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co				
	death ms 2%	Funerai	80 Park Lane 11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	21921 3. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		rican Indian,			
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-1 show the Medical Examiner must be routified at		1 ☐ Never Married 2 🖾 Married	1 ☐ Yes 2 🔯 I If Yes, Give	No	If Yes, specify Cuba 1 ☐ Yes 2 💆 No	sn, mexican, Puerro  Specify:	Hican, etc.)	Black, White	e, etc.			
00	tural'	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a. Dec	cedent's Usual Occup	ation		16b. Kind of Business/	hite			
215	within 72 ene. than "na he Madii	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(Gi	ve kind of work done . DO NOT use retired	during most of work d)	ing	TOD. TAITO OF DOSKIDGO	moustry			
21	e filed with Il Hygiene othar thai			2	'	xecutive			Laundry/Dr	y Cleaning			
and	e d la la la la la la la la la la la la la	o Be	17. Father's Name (First, Middle, Last)  James Kniveton				Frances		Maiden Sumame)				
Maryland 21215-0036	shou nd N man	Ĕ	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	iling Address (Street			r, City or Town, State, 2	Tip Code)			
	C = 64 F		Ruth K. Fackentha	l/Sister	1945	Sweedsfor			Pennsylva:				
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, ci	position (Name of rematory or other place	») Мау	4,	20c. Location - City or Philadelph:	ia,			
Itin			<ul><li>'4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	90 ) -		ll Cremato 22. Name and Addre		_	Pennsylvan	ia			
B	permit. Departifimportiany injury		1 Donald &	. Nech		22 Name and Addre HICKS HOME LO3 W. Sto			.A. kton, Maryl	and 21921			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Constructions and Posts										
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or consequence of):										
	Examiner		f.		a consequence or):	27							
7	Pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							-			
0	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	. Due to (or as	a consequence of):								
68760	ysicial	edical		L									
	- O d	Med	IF FEMALE:	0 - 16									
Вох	death cert e attendin ed for use a	cian/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliment	very Day Year			
P.O.	that the de led by the a detached t	Physicia	1 Yes 2 No 9 Unknown	9□ Unknown									
	es be	by	Part II. Other significant conditions con	tributing to death be	ut not resulting in the	underlying cause give	en in Part I.		pacco use contribute to				
örc	w requir been si should	eted						1  Ye		obably 4 □Unknown			
Vital Records,	e tar has	Completed						24a. Was autops perform	y prior to c ned? death?	opsy findings available ompletion of cause of			
ital	ıysician: Th is certificate director, pag	Be C	25. Was case referred to medical				26. Place of Death	1 X Yes 2 1 Check onl on	, -	2∐ No			
of V	d s	2	M 162 5□140	ospital: 1 ☐ Inpatie			4   Nursing Ho		ence 6 🛣 Other (Spec	ify) scene			
ouo	ling After fune	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	47200	28b. Time Injury 4:30	Worl	vat ⟨? Yes 2. MNo	28d. Describe ho	ow injury occurred	1			
Division	Attanding or death. actor: After by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, s				reet and Number or Rui	al Route Number			
Ö	ital or rs afte ral Dira led in I	Cert	4 to Hollidde	building, etc	- Come		4	80 Park 1		ns Martes			
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination and/or i	ath occurred at the tim investigation, in my or	ne, date and place, pinion, death occurr	and due to the ca	ause(s) and manner as ate and place, and due	stated. to the cause(s)			
	To the within 2 To tha complet	Mec	29b. Signature and the of contifier		.cod.	29c. License	number	29	9d. Date signed (Month	Day, Year)			
	1		XXXX	X VV		oa	ME	P	APRIL 30,20	04			
	4		30. Name and address of person who co	mpleted cause of de									
	Sta	te	31. Date filod (Month, Day, Year)	32. Registra	ur's Signature	renn St	reet, Bal	timore,	Maryland 2	1201			
	Registr	•	MAY 1 8 2004	4	1	*	•						

**ORIGINAL** 

	1			Pieas		f Maryland /								_	ie.		
		•	For State Registrar			,		rtificat					Reg. No.	9136	) 4	15	859
	Physici	an	1. Decedent's Name (									2. Date of De Month	Dey	, , , , , ,	eer	3. Time o	
	/Medic	al	DAVIS		HUDSON	mber)		4b Cilv.	Town, or	Location of	of Death	MAY		2004 County of		6:25	<u>ра "</u>
	Examin	er	4e. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death														
	Funeral		5. Social Security Num		. Sex	7. Age (In yrs. last				If Under Hours		8. Date of Bir (Month, De	rth	9	Birthpi	ace (State	or Foreign
ŀ,	Director		221-20-8. Usual Residence of De		1 <b>X</b> M 2□F	70	Yrs.					Mar 2	7 19	34	Del	awar	:e
	ow ow			Ob. County		10c. City, To	own or Lo	ocation							10	Od. Inside (	City Limits
	a-f eh	tor	DE	Kent		Fre	der	ica								1 🗌 Ye	s 2 XNo
	3e or 28	i Director	10e. Street and Number 4187 Ba		s Chape	el Rd.		10f. Zip	Code 199	946			-	S • A		try?	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ite marked other than "natural", or Items 23a or 28a-f ehow aurnatic event, the Maddeal Evanance must be motified at	by Funerai	11. Marital Status 1 X Never Married 3 □ Widowed 4		Armed Fo	2 X No		Was Deced If Yes, spec				ecify Yes or No Rican, etc.)	0-	14. Race - Black, Specify:	White, 6		
ğ	2 hou	ted	/Specific	5. Decedent's	Education grade completed)	11	6a. Dece	dent's Usua kind of wo	al Occupa	ation	t of work	rina	16b. Ki	ind of Busi	ness/Ind	lustry	
21	thin 7	Completed	Elementary/Second		College (	1-4or 5+)	life.	DO NOT us	se retired	)	t or work	ang.		enta			
Maryland 21215-0036	filed w Hygiel other ti		17. Father's Name (Fit	rst. Middle, La	ist)		I	Disab	led		ər's Nam	e (First, Middle		anic		ed	
au	ental I	To Be	Howard			r.						Luff		,			
ary	should and Men marka umatic	-	19a. Informant's Nam				9b. Maili	ng Address	(Street a	and Numbe	er or Rui	al Route Numb	er, City o	r Town, St	ate, Zip	Code)	2163
	5 € Z = 3		Galena F		1 Home	(Funera				118							).
timore,	0 0		20a. Method of Dispos 1 X Burial 2 □		Bemoval from	State ceme	etery, crei	matory or o	ther plac		5/7/	Date / O /		cation - Ci		wn, Stete DE	7
Ē	permit. Peg Department Important; I eny injury o		*4 □ Dopation 5			Ваг		ts Ct									
Ba	Departm Departm Importa eny inju		1	10	Y	M00510		18 We	est	Cros	ss S	Home of	lena	ephe MI	n I	21635	5
B				ailure. List of	omplications that only one cause on e	aused the death. Deach line.	o not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory a	irrest,			Approxima Interval Be	etween
	Pnysician /Medical	i	Immediate Cause Final disease or condition resulting in death a. Non Small cell lung cardions will bore mats 3 mo								2.						
wig	Examiner		Due to (or as a consequence of):									Iw.	· C				
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?	te be executed ysicien and le burial-transit	Examiner	Cause (Disease or inj that initiated events resulting in death) Las	ury	c	ype II	D,	Nbe4	es	mol	litu	0				6 m	יסו
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O	nding th. : Afte	tlon	1 □ Natural 2 □ Accident	5 Pending investiga	(Mon	th, Day Year)	Injury	м	28c. Injun Work 1 🔲 '	k? Yes 2□	No		·				
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	Hospitel or 24 hours afte Funeral Dir stely filled in	edical C			ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  I Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								(s)				
	To the l within 2. To the I complet	Me	29b. Signature and tit	e of celaries	\			290	c. License	e number			29d. Dai	te signed (	Month, L	Dey, Year)	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [ For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 11:08 PM VARNON EUGENE HADDAWAY MAY 05 2004 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1**X** M 2□ F 75 MAY 21, 1928 MARYLAND 213-22-5515 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No QUEEN ANNE'S CHESTER Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 21619 USA 117 DUNDEE AVENUE Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married 1952-1 ☐ Yes 2X No WHITE Specify Specify: þ 3 Widowed 4 Divorced 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CORRECTIONS OFFICER **MILITARY** 12 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALICE WRIGHTSON VARNON EUGENE HADDAWAY 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED HADDAWAY/WIFE 117 DUNDEE AVE., CHESTER, MD 21619 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition t X Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL 05/10/2004 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) PARK 21. Signature of Furieral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one empse on each line. Immediate Cause (Final allav resulting in death) Due to (or is a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Leader of the list) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

**Funeral** 

Director

nd other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at

death with the Maryland

within 72 hours after

should be find Mental F is marked

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum

Baltimore, Maryland 21215-0036

and the attending physicien ç signed by pe been certificate has page 2 this

Physician/Medical ð Completed

tuneral director. Atter the

Division of Vital Records, P.O. Box 68760,

Be Certification: To

law requires that the death certificate be executed or Attending Physician: death. hours after death unerel Director: tilled in by within 24 hours a JEA: 8 ( PHO)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 3 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 ☐ Yes 2 ☐Mo 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Maturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11.2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

2.c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID SMITH M.D., 29466 PINTAIL DRIVE, SUITE 5, EASTON, MD 21601

State Registrar

Medical

			1 - For State Registrar	State of Maryland		artment of I			iene g. No. 20 (	14 1586		
	Physici	an	Decedent's Name (First, Middle, La:  EDWARD WI	·	TD			2. Date of Death Month	n D <i>a</i> y Yea	3. Time of Death		
	/Medi			LLIAM HARTLOVE	, JK.				5 2004			
	Examir	ner	4a. Facility Name (If not institution, give				or Location of Death		4c. County of D			
			CORSICA HILLS N  5. Social Security Number 6. S		et hirthday)	If Under 1 Year	EVILLE  If Under 24 Hrs.	0 D-4- / Dist	QUEEN			
2.x	Funeral Director			M 2 □ F 63	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JAN.5, 1	941 MAF	Birthplace (State or Foreign Country) RYLAND		
	4 within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-1 show the Michal Examinat for Intelligial	tor	10a. State 10b. County MD QUEEN		Town or Lo	cation H HILL				10d. Inside City Limits 1 ☐ Yes 2X No		
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Cilizen of What	Country?		
	th wit	a D	305 MERRICK CORN	ER ROAD		216	23		USA			
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian,		
9	afte or It	F	1 ☐ Never Married 2 X Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 X No		rican, etc.)	Black, W	WHITE		
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	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)			ROOK DILL		a (Final Middle M				
Maryland		To Be	EDWARD WILLIAM I	HARTLOVE, SR.				e (First, Middle, M	Alden Sumame) HITTINGT	ON		
	D = 7. =	7 9	19a. Informant's Name/Relationship (T				CORNER RO					
nore	0 0		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	ce of Dispo netery, crem	sition (Name of natory or other place LLE CEME	сө)	Date 2	0c. Location - City	or Town, Slate		
Baltimore,	permit. Pag Department Important: I any injury o		21. Sign thre of Fineral Service Licen		FÉ	Name and Addre	ss of Facility	NEWNAM	FUNERAL 1	HOME, P.A.		
	40244		23a. Part1. Enter the disease, or com	for	408	S S. LIBI	ERTY ST.,	CENTREVI	LLE, MD	21617		
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O. Box	that the death certificate and by the attending physic detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deal 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	elivery Day Year		
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cords,	w requires that been signed b should be deta	ted by								Probably 4 Unknown		
Ë	The law ate has b page 2 sl	Completed						24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of		
VII	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Manual				(Check only one)	2			
0	Physician: this certific ral director,	2	1 192 512440		VOutpatient		47 Indising Ho		ce 6 □Other (Sp	ecity)		
	Attending F r death. ector: After by the funera	ertification;	27. Manner of Death    Ratural   5   Pending     2   Accident   investigation	(Month, Day Yeer)	3b. Time of Injury	28c. Injun Work	yat k? Yes 2 □ No	28d. Describe how	injury occurred			
	- 9 -	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specify)		,		City or Town,	State)	Rural Route Number,		
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	edical	29a. Certifier (Check only one)  Check only 2 Medical Example 1	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my o	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as and place, and du	as stated. se to the cause(s)		
	To the within To the comp	M	29b. Signature and title of certifier			29c. License		290	I. Date signed (Mor	nth, Dey, Year)		
)			1 /2 4 // Spr	wo.			37036		5/7/2	407		
5	46		30. Name and address of person who co	rose 2/0	PDI	1) wash	, Drive	Cheste	5/7/2 Mi) 0	1619		
1	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0	32. Registrar's Signatur		(hools)			-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

					artment of Health and	Mental Hyg	giene				
			1 - State Registrer	Cei	rtificate of Death	R	eg. No 2004 158	362			
1	Physici	an	1. Decedent's Name (First, Middle, Last)	11		2. Date of Dea Month	Day Year	f Death			
	/Medic	al	JANE CATHERINE	प्रभू			29, 2004 1815	PM			
	Examin	er	4a. Facility Name (If not institution, give street and	Ι Λ .	4b, City, Town, or Location of De		4c. County of Death				
	Funeral		50 E. Franklin St 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Itagers town		Woshington  9. Birthplace (State)	or Foreign			
١.	Funeral Director		214-09-0638		Months Days Hours Mi	n. (Month, Day, March	(Year) Country)				
	p.		Usual Residence of Decedent			march	12, 1919 Pary Tailo				
	arylar show	ř	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside C	•			
	Be-f	ectc	Maryland Washington	Hagers				2 No			
	with t	Dİ	10e. Street and Number 50 Fast Franklin Stree	_	10f. Zip Code	1	0g. Citizen of What Country?				
	leath	Funeral Director	11 Marital Status 12. Was I		Vas Decedent of Hispanic Origin?	Specify Yes or No-	U.S.A.				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-1 show eny injury or other treumetic event, the Modical Examility of other treumetic event, the Modical Examility or other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic event, the Modical Examility of other treumetic events.	by Fun	1 X Never Married 2 ☐ Married 1 ☐ Y	1 Forces? es 2 1 No Give	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pue t □ Yes 2 No Specify:	erto Rican, etc.)	Black, White, etc.  Specify: White				
215-0036	2 hour	edk	15. Decedent's Education	or Dates:	dent's Usual Occupation		16b. Kind of Business/Industry				
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	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)			ame (First, Middle, I	Maiden Sumame)				
yla	ould b Ment arked	2	Paul Tudro Hopp			beth Elle					
Maryland	12 sh n and 7 Is rr reurr		19a. Informant's Name/Relationship (Type, Print)  Lawrence P. Hopp/Nephe		ng Address (Street and Number or I						
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nor	ages ant of t; If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State Rose Hill	sition (Name of natory or other place)	3, 2004	· ·	لمسمار			
altimore,	nit. Partme orten injur		21. Signature Fun ral Service Ligensee				Hagerstown, Mary				
ä	Per Imp		Il found of		Fiery Fuenral Horstown, Maryland						
r	3/		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not ento	er the mode of dying, such as cardi	ac or respiratory arre	est, Approximate Interval Bet	е			
	Pnysician		Immediate Cause (Final disease or condition	1	dial Intarcti	, KN	Onset and I				
	/Medical Examiner		resulting in death)	to (or as a cons nce of):							
	LAAIIIIIei	_	Sequentially list conditions, if any, leading to immediate		'ARDIOVAsoular l	Sisease					
	ted 1sit	Examiner	Cause (Disease or injury	to (or as a consequence of):							
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Вох	eath certif attending for use a	Physician/M	230. Was decedent pregnant	outcome of pregnancy re birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery				
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ecords,	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a:	d by	The state of the s	o doddir but not rosulting in the di	conying cause given in raiti.	1 Ve					
S	w req	Completed				24a. Was ar					
Y,	The lav	duc				autopsy perform	prior to completion of ca death?				
Vital		0	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 eath (Check only one	No 1 Yes 2 No				
	nysici iis cer direc	ToB	examinat? 1 Pes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpatient	Other	Home 5 Reside					
0	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending (N	te of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe ho					
S10	uttendi death. ctor: A y the fu	cath	2 Accident investigation								
Division of	or At after d Direct in by	Certification:	determined 200. FI	ace of Injury - At home, farm, stre ilding, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Numb , State)	per,			
_	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physicien: To	the best of my knowledge, death	occurred at the time, date and place	e, and due to the ca	use(s) and manner as stated.				
	the H hin 24 the Fu	Medical	and m	e basis of examination and/or invalent and/or invalent stated.			te and place, and due to the cause(s)				
	To To	Σ	29b. Signature and title of partille	N. T.	29c. License number		d. Date signed (Month, Day, Year)				
	1.3		1 Torlbert, II	ause of death (Item 23a) (Type, F	1740884	A	pril 29, 2004	,			
5	74		30. Name and address of person who completed of Thomas J. Gilbert Z	7 D.O. FACEP	While tan Cour	tu Hoxo: to	pril 29, 2004 1 Hagerstown, MD 2	חשרוו			
	Sta	e		. Figistrar's Signature	1 - Warring Con Coun	of wast on	1 myers court in 2	1170			
	Registra	ar	mn v 3 2004	Afrew D. Op	ande						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:35 AM Year Month. Say **Physician** April ZOOLI CHARLES WEST HOLDER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Keedy Boon Slovino
If Under 1 Year If Under 24 Hrs.
Hours Min. 9. Birthplees (State or Foreign Home Nursing ahrney 8. Date of Birth JAN. 29, 1905 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 → M 2 □ F Days Hours 99 Yrs 218-07-9371 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No **BOONSBORO** Director WASHINGTON MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 U.S.A. 8507 MAPLEVILLE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married ò 1 ☐ Yes 2X No Specify Specify If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RAILROAD MACHINIST 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fith Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be CARRIE BELLE WEST RICHARD HENRY HOLDER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4336 MAIN STREET, ROHRERSVILLE, MARYLAND CHARLES R. HOLDER, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State PLEASANT VIEW CEM. 5/3/2004 ROHRERSVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Loens 22. Name and Address of Facility 7606 OLD NATIONAL PIKE A. Zimmerman BAST FUNERAL HOME 21713 BOONSBORO, MARYLAND Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or experications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Embolism **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner umon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death
4☐Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ö 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Whiknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes siyi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide pellil To the Hospital 1 🖰 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and type of certifier 043590

State Registrar

DHMH 17 Rev 1/2001

Maryl

Itimore,

Division of Vital Records, P.O. Box 68760,

BLUD SMITHSBURG MD 21783

d address of person who completed cause of death (Item 23a) (Type, Print)

PISTEN

22511 JEEKSUM

32. Registrar's Signature

22911

15864 State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 **Physician** April Wayne Garfield 2004 8:35 A M Henry /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 815 Virginia Avenue Washington 8. Date of Birth (Month, Day, Year) May 26, 1951 Birthplece (State or Foreign Country)
 Mary Land 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 212-58-7622 52 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits ir then "natural", or Items 23s or 28e-t show the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Virginia Avenue 21740 USA filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
XXYes 2 No 1966- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify 1970 3 ☐ Widowed 4 ☒ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Surveyor permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: It item 27 is marked other tt
any injury or other traumatic event, this
once. Engineering Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Scott Garfield Henry Betty Gray ပ Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williamsport, Maryland 16 Shawnee Terrace <u> Betty J. Henry – Mother</u> 21795 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐Denation 5 ☐ Other (Specify) Smithsburg Crematory Apr.29,2004 Smithsburg, Maryland 2 Signature of Funeral Service L OSBOTNE Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dilateo CARDIUM MIMERIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate has 1 Yes 2 □ No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Tes, 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Attending Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the hours after deatl uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ŏ within 24 hours To the Funeral 📿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie comptetely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier  $_{\chi}$ \ eted cause of death (Uem 23a) (Type, Print) 30. Name and add Campus Rd Medical 130 32. Registrar's Signature 31. Date filed (Mont State Registrar

			ricasc	State of Mar	vland /	Denartme	nt of Ha	alth and M	lental Hy	niene	-09.0.0.		
			1 - For State Registrar	State of Mar	ylanu /	Certifica	ate of D	eath	leritai riy	Reg. No.	2004	158	865
4 10	1		1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Yeer	3. Time of C	Death
	Physicia		Frederick H. H	ilton, Jr	•				May	1	2004	1:15	A M
	/Medic Examin		4a. Fecility Name (If not institution, give	e street and number)		4b. C	ty, Town, or L	ocation of Death	- 17	4c. (	County of Death		
			Country House,	15 Cumber	land	St. Cur	nberla	ınd			Allegar		
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last b	Month		If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, De	y, Yeer)	9. Birthp Cour	olece (Stete or ntry)	Foreign
	Director		165-22-8409	A M ZUT	91	Yrs.			Aug 28	,191	2 Penr	isylva	nia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Location					1	10d. Inside City	y Limits
	Aarylan I show	ō	Maryland Alle	gany	Cumb	erland	Ĺ					1.X Yes	2 □ No
	the the same	Director	10e. Street and Number			10f.	Zip Code			10g. Ciliz	en of What Cou	ntry?	
	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. A contract than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be rediffed at	Ö	15 Cumberl	and Stree	t	2	1502			US	SA		
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was De	cedent of Hisp	anic Origin? (Spe Mexican, Puerto	ecify Yes or No	- 1	4. Race - Ameni Black, White,		
0	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give	)		pecity Cubari, 2⊠ No		rticari, etc./			nite	
3	ral', c	d by	3 ☐∰Vidowed 4 ☐ Divorced	Year or Dates:			2,0,110						
ה ה	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	a. Decedent's U (Give kind of life. DO NO	work done du	on ring most of work	ing	16b. Kin	id of Business/In	dustry	
Z	Athin hen	пр	Elementary/Secondary (0-12)	College (1-4or 5+									
V	tygie her t		12 17. Father's Name (First, Middle, Last	5+	11	'eache		8. Mother's Name	e (First, Middle		lucatio Sumame)	)n	
=	Z in D	Be	Frederick A. H					Jean D					
	should be filed within and Mental Hygiene. s marked other then " aumatic event, the Men	2	19a. Informant's Name/Relationship (		19	b. Mailing Addr	ess (Street an	d Number or Rura	al Route Numb	er, City or	Town, State, Zip	Code)	
Σ	t t		Elaine K. Solo		1	2300 1	Henry	Drive,	LaVal	e, N	4D 2150	)2	
กั	permit. Pages t an Department of Heal Important: If itsm 2 sny injury or other once.		20a. Method of Disposition		20b. Place	of Disposition (	Name of		Date		cation - City or To	own, Slate	
baltimor	ages ant of st: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	Removal from State	Hillo	rest 1	Memori	al May	3, 200 k'	Cun	nberlar	nd D	215
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ă	Depariment of the services once		Douglas )	Stadon	$\supset$	1303	Nati	onal Ht	Jy LaV	ale	MD_21	502	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	aplications that caused to	he death. Do	not enter the r	node of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	M.	100	rdia	1 I	afarc.	hum			Onset and D	
	/Medical		resulting in death)	Due to (or as a	consequence	e of):		1 1 2 1					
	Examiner		Sequentially list ours this as	b									
	D =	iner	sequentially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):							
	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence	a of):			_				
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280	death certificate to a tending physical for use as the tending to the tending physical for use as the tending tending the tending tend			d									
	certifica Iding ph	ician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						2	3d. Date of deliv	ery	
X Q Q	death e atten	ciar	in the past 12 months?	1□Live birth 2 4□Pregnant at t			c pregnancy (specify)				Month	Day Y	rear ear
j.	0 0 2	Physi	9 Unknown	9 Unknown								_	
S,	requires that the der een signed by the a hould be detached f	by P	Part II. Other significent conditions	. 7			ig cause giver	in Part I.	23e. Did	obacco u	se contribute to t		
ğ	w require been sig should b		1/zhpim	ers Dr	5055	P			1 🗆	Yes 2	□No 3□Pro	bably <del>▲⊟U</del>	mknown
ecord		piet							24a. Was		24b. Were auto	opsy findings a	available ause of
ř	The I	Completed								ormed?	death? 1 ☐ Yes	_	
Vital H	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only	one)			
<u>o</u>	S D	2	1 ☐ Yes 2 No	-	t 2 ERV		DOA Other	4,8 Hursing no			Other (Speci	<i>fy</i> )	
0	ding Pt h. After th funeral	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b	. Time of Injury	28c. Injury a Work?	,	28d. Describe	now injury	occurred		
Division	Attending r death. sctor; Atter by the fune	cati	2 Accident investigate 3 Suicide 6 Could not			M		es 2 □No	28f Location (	Street an	d Number or Rur	al Route Num	her
$\leq$	of or Attendated after death	Certification:	4 Homicide determined		(Specify)	iarm, street, ia	стогу, оптсе		City or To	wn, State,	)	A1 7 10010 1401111	<i>D</i> 07,
_	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in the completely filled in the complete or the filled in the f		29a. Certifier 1 Certifying P	Physician: To the best of	f my knowled	ge, death occur	red at the time	a date and place.	and due to the	cause(s)	and manner as	stated.	
	24 hos Fun etely	Medicai	(Check only 2 Medical Exa	aminer: On the basis of and manner stat	examination a	and/or investiga	tion, in my opi	nion, death occur	red at the time,	date and	place, and due	the cause(s)	)
	To the Hos within 24 ha To the Fun completely	₩ We	29b. Signature and title of confider	26	7		29c. License				e signed (Month,		
ł	12		1//	6/1/	a. M	1/1	$\supset$	35/3	5		5/3/	04	
	nel		30. Name and address of person who	o completed cause of de	au (Item 23a	(Type, Print)		35/3 Clan D	10	,	, ,		-
	11000		Ihomas E	= Chaple	1/1	11) 9	125	Charle	164	mb	Mandi	MDZ1	SOZ
		ate	31. Date filed (Month, Day, Year)	32. Flegistra	r's Signature	1 ho	21/1						
	Regist	rar	MA. 0 0 2004	4	1 man	jugit	in						

		4	1 - State of Maryland / Department of H Certificate of I	lealth and M Death		ene 2001	+ 15866
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic	_	JOHN L. HINKLE		MAY 0	1 2004	2130 M
	Examin	er		r Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	ALLEGANY 9. Bird	thplace (State or Foreign
	Director		220-05-7377 X M 2 F 86 Yrs. Months Days	Hours Min.	OCT 27,	1917 WEST	VIRGINIA
	/land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ith the Marylar or 28a-f show	ctor	WV MINERAL FORT ASHBY				1 □ Yes ŽŽNo
	with th	Director	10e. Street and Number  ROUTE 2. BOX 324  10f. Zip Code 2671	0	10	g. Citizen of What Co	ountry?
	after death w	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of H		city Yes or No-	14. Race - Ame	
200	filed within 72 hours after death with the Maryland Hygiene. Hysiene. Industrial; or Items 23a or 28a-f show with the Medical Evaniral must be notified at	by Fur	Amned Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Sive WWII  1 Yes 2 No  1 Yes 3 No	an, Mexican, Puerto F  Specify:	Rican, etc.)	Black, Whit	e, etc. HITE
5	n 72 hours natural',	eted	15. Decedent's Education 16a. Decedent's Usual Occup. (Specify only highest grade completed) (Give kind of work done of	ation during most of workir		6b. Kind of Business	
7	within ane. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  1 2 FACTORY We	ORKER		ELLY-SPRIN IRE COMPAN	
ם ס	filed within I Hygiene.  other then	8	17. Father's Name (First, Middle, Last)	18. Mother's Name			VI.
yland	should be and Mental marked o	To B	GEORGE W. HINKLE	CLARA	WAGON	ER	
Z Z	B 8 8 8		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  LODEMA P. HINKLE / WIFE ROUTE 2, BO			•	Zip Code) 26719
ย์	ges 1 and it of Health If Item 27 or other to		20a. Method of Disposition 20b. Place of Disposition (Name of		-	0c. Location - City or	
Dallillo	Pages ment of ant: If It ury or o		f Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Cemetery, crematory or other place semetery, crematory or other place semeters, crem		/2004	FORT ASH	BY,WV
Dall	permit. Pages Department of Important: If It eny injury or o	]	21. Signature of Funeral Service License UPCHURCH UPCHURCH P.O. BOX	FUNERAL HO 1260 – FOR	OME, INC	,wv 26719	9
ď			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	ig, such as cardiac or	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. MRSA Bacteremia				Oliset and Death
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•	xecute r and al-tran	Examin	that initiated events resulting in death) Last C. Due to (o as ansequence of):				
00/00	icate be executed physician and s the burial-transit	dicai	. Chronic Congestive Hear	t Failure			
XO	n certifi inding use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
o O	The law requires that the death certif the has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months?  1  Yes 2 No 9  Unknown  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		· · · · · · · · · · · · · · · · · · ·	Month	Day Year
L O	ss that gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords,	require een sig		Chronic Renal Insufficiency, Coronary	artery	1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Munknown
	The law ate has b page 2 st	Completed	Disease, Hypertension, Lower Gastroin Bleeding.	testimal	24a. Was an autopsy perform	prior to death?	itopsy findings available completion of cause of 2 No
B	Physiclan: rthis certifica ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death			
5	Phys or this oral dir	); To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury	vat 2	ne 5 🗌 Residen 28d. Describe hov	ce 6 Other (Spec	cify)
5	ath. arth. or: Afte	ation	2 Accident	k? Yes 2 □No			
DIVISION	of or Atter de l'Director din by the	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical C	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time of the desired of the pass of examination and/or investigation, in my or and manner stated.	ne, date and place, a pinion, death occurre	and due to the cau ad at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To the	Me	29b. Signature and title of certifier 29c. License	e number	296	d. Date signed (Monti	h, Day, Year)
1	OLVA		Dalachet Namaby D 58	655		5/3/0	4.
(	nes		30. Name and address of person who completed cause of death (Item 3a) (Type, Print)	aula Ma		21621	
	Sta	te	Nawab, Sahahat, MD, P.O. Box 21.5 Grant  31. Date filed (Month, Day, Year)  32. Registrar's Signature	sville, Ma	ryland	21536	
	Registr		MAY 0 6 2004 Genera & Spark				

**BALTIMORE, MARYLAND 21215-0020** 

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	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEP Cert	ARTMEN IFICAT	T OF H	EALTH AND DEATH	MENTA	L HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Lest)	TOWERS					MONT	OF DEATH	AY	YEAR.	. TIME OF		
	JAMES W. J	ONES  5. SEX  6. AGE (					FP		0 2	004	11	P	
	221-28-0307	1 📉 M 2 🗆 F	in yrs. last birthd	S. MONTHS		HOURS MIN.	JAN	of BIRTH h, Day, Year) 15 19	44	Country)	ACE (State AWARE	-	
DIRECTOR	9e. FACILITY NAME (If not institution, give s 17766 COOLSPRI			8b. CIT		RYDEL	EATH			CAROL			
ᇤ	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY	Y	10c.	CITY, TOWN	OR LOCATI	ON				- 12	Od. INSIDE	CITY	
H	MARYLAND CA	ROLINE		MARYI						1	LIMITS?	T	
	10e. STREET AND NUMBER					ZIP CODE		<del></del>	10g. CITI	ZEN OF WH			
ER	17766 COOLSPRING	ROAD				21649			- 2-4	USA			
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR DA	2 NO	13.	If yee, spe	NDENT OF HISPA	en, Puerto	i? (Specify Yes Rican, etc.)	or No—	Bleck, 1	- Americen White, etc.	Indien,	
B√	3 Widowed 4 N Divorced					A NO Specia	·y.			Specify:	WHI	TE	
Ĕ	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18e. DECEDEN (Give kind	of work done	during mos		18b	. KIND OF BUS	USTRY				
COMPLETED	Elementary/Secondery (0-12)	College (1-4 or 5+)		T use retired.)  SMTTH			E	QUINE	INDU	STRY			
BE CO	17. FATHER'S NAME (First, Middle, Last) WILLIS E. JONES	Middle, Maiden FELLOW											
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAIL	ING ADDRES	S (Street an	d Number or Rural	Route Numi	ber, City or Tow	n, State, Zip	Code)			
F	CHARLES E. JONES/BROTHER 3302 BARRATTS CHAPEL ROAD, FREDERICA, DE 1												
	20e. METHOD OF DISPOSITION 1 Dyouriel 2 Cremetion 3 TRemoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of cematery, crematory or other place) ODD FELLOWS CEMETERY 5/5 CAMDEN, DE												
	21. SIGNATURE OF FUNERAL SERVICE LIC					ADDRESS OF FA				,			
	1 Himaer	m Start		41	6 FEI	DERAL ST	REET	. MILT	ON. I	DE 199	968		
	23. PART I. Entar the diseases, or o	complications that caused	the death. D						-		Approx	kimate	
	anock, or naart tallure. List only one csuaa on each lina.												
	resulting in death)												
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):  Sequantially list conditions, If any, laading to immediate cause. Entar UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):												
RTIFIC	CAUSE (Disease or Injury that Initiated avants resulting in daath) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):								-	
	PART ii. Other algnificant condition	a contributing to death by	ut not resultir	a in the w	nderlying	Course obvers in	Post I				1		
8			at their roughts	g III tile ui	idaniying	Cadae givan iii	rait i.	PERFOR	MED?	AV	ERE AUTOPS AILABLE PR OMPLETION (	IOR TO	
							[	1 YES 2	NO	DF	DEATH?		
≥							-			1 1/	YES 2	□ NO	
¥	25. WAS CASE REFERRED TO MEDICAL				26. PLA	CE OF DEATH (Ch	eck only on	3)			V   / 1		
Sic	EXAMINER?  1 PYES 2 NO	HOSPITAL: 1 Inputient 2 I ER/Output	atlent 3 🗆 DO/	OTHE		5 @ Reeldence	6 🗆 Other	(Specify)					
Y PHYSICIAN: MEDICAL	27. MANNER OF DEATH  1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)						CRIBE HOW IN	JURY OCC	URED			
COMPLETED BY	2 Accident Investigation 3 Suicide Could not be detarmined	28a. PLACE OF INJURY building, etc. (Speci	20. PLACE OF BUILDY						nd Number	or Rural Rout	e Number,		
٦	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) and mennar ee attated.												
N N	(Check only one) 2 MEDICAL EXAMINE	R: On the beale of examination	and/or inveatig	tion, in my	opinion, dea	th occured at the	time, data	and pleca, and	dua to the	cause(a) er	d mennar 4	e stated.	
	296 SIGNATURE AND TITLE OF CERTIFIER		DE	VIV		29c. LICENSE NUN		/ 1		SIGNED (M		- 11 11	
10 BE	30, NAME AND ADDRESS OF PERSON WHO	enseu MD	M	E.		D14	66	4	► /Y	144	08	2004	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, C.E. JENSEN M.D. POB #C

DHMH-16 Rev 1/89

			For	State of Maryland	•		Mental Hy	giene 200	4 15868
	_		State Registrar  1. Decedent's Name (First, Middle, Last)		Certifica	te of Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia /Medic		Marjorie	Elizal		Johnson	May	01 200°	4 1820 4
	Examin	er	4a. Fecility Name (If not institution, give s	11 -1 1 /	toc (1)	, Town, or Location of Death		4c. County of De	am
	Funeral		5. Social Security Number 6. Sex	T7.L	ast birthday) If Under Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day 7 10		hirthplace (State or Foreign Country) MID
14	Director		220 - 26 - 8592 Usual Residence of Decedent		J		7 10	1730	
	urylan phow	Ļ	10a. State 10b. County		, Town or Location				10d. Inside City Limits 1 ☐ Yes ※ ☐ No
	Ne Ma	ecto	MD KENT  10e. Street and Number	CH	ESTERTOW	N ip Code		10g. Citizen of What	
	with t	Funeral Director	7498 POPLAR AVE			.620		USA	300 my .
	death	nera		2. Was Decedent Ever in U.S Armed Forces?		edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No-		merican Indian,
21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It amarked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Exeminer must be natified at	þ	1 ☐ Never Married 2 ☐ Married  Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Tes, sp		o riodii, etc.)	Specify:BI	
2-0	72 ho 'natur	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us (Give kind of w	ork done during most of wor	rking	16b. Kind of Busines SENIOR	
121	within ene. than *	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	SOCIAL				Social Ser.
	Hygie other	40	17. Father's Name (First, Middle, Last)	<del>-</del>	DOGINE		ne (First, Middle,	Maiden Sumame)	500242 5621
Maryland	uld be Vental irked c	To B	CHARLES H. SMIT	`H		BERTH	A GOLDS	BORO	
lan)	2 sho and I is ma		19a. Informant's Name/Relationship (Type		_	ss (Street and Number or Ru			
	1 and Health em 27		LORI JOHNSON - DA  20a. Method of Disposition	20b. Pl	ace of Disposition (N	oplarAve Cl	nestert Date	OWN, MD 20c. Location - City	
nor	nit. Pages 1 an artment of Heal ortant: If item 2 injury or other		X Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify)	amoval from State	metery, crematory or ies U.M.		0/2004	Chestert	own. MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License		22. Name a	and Address of Facility Ke	enneth	Walley F	uneral
ä	Depa Impo any ii	9	Josepe O, W	alley (WOOO2		ce P.O.Box			
	Physician		23a Part1. Enter the disease, or complications, or heart failure. List only on immediate cause (Final	e cause on each line.			or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	rence of):	Concinous			
	Examiner	<u>.</u>	Sequentially list conditions,	Due to for an a normedy		Concinouna			+
	nsit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury		of No Oil				
oʻ	be executed sician and burial-transit	Exal	that initiated events cresulting in death) Last	Due to (or as a consequ	ience of):				
3760	3 2 9	licai							
x 68	eath certificat attending phy I for use as thi	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnar	ncv	3-57		23d. Date of	dolivon
Вох	atten atten	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			Month	Day Year
Ö.	at the de by the a tached f	hysi	9 Unknown	9 Unknown					
Vital Records, P.	es the gned be de	by	Part II. Other significant conditions con	stributing to death but not resu	ulting in the underlying	cause given in Part I.			e to the cause of death?  Probably 4 Dunknown
CO	e law requir has been si je 2 should	Completed					24a. Was	an 24b. Were	autopsy findings available to completion of cause of
H H		Com					perfo 1 ☐ Yes	rmed2 death	?
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			ath (Check only o		
of		.: To	1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatient 3	28c. Injury at		dence 6 \( \text{Other (S)}\)  now injury occurred	pecify)
ion	토 . 둘 5	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division	of or Attendater death Director: Jin by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor)	ory, office	28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or Al within 24 hours after C To the Funeral Direct completely filled in by	edical C		sician: To the best of my knowner: On the basis of examinat and manner stated.					
	To the within 2. To the complet	Me	29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Mo	-
			Q @ austo	S Jums		123889		5/3/0	4
			30. Name and address of person who co			OHEGE	N. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7.	D. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	4600
	< c+	ate	JOHN C. ARRABAL  31. Date filed (Month, Day, Year)	32. Registrar's Signal	HIGH ST	. CHESTERTO	JWN, MA	KYLAND 2	1620
	Regist		MAY 0 4	2004	A Coo	50			

			. For	State of Maryland / Depart			ene
			1 - State Registrar	Cei	rtificate of Death		No. 2004 15859
п	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	/Medic		Laird Gwily			April 28	
	Examin	er	4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Deat	n	4c. County of Death
			23009 Timber Creek  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Clarksburg If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Montgomery  9. Birthplace (State or Foreign
	Funeral Director			M 2□F 78 Yrs.	Months Days Hours Min.	(Month, Day, Yo	ear) 9. Birthplace (State or Foreign Country) 1925 Ohio
	ט		Usual Residence of Decedent			11.51-1-1	
	how	_	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	Directo	Maryland Montgomer	y Clark	sburg	140-	
	death with the Maryland rns 23a or 28a-f ehow rmust be notified at		10e. Street and Number	T	10f. Zip Code		Citizen of What Country?
	eath	Funeral	23009 Timber Creek		20871 Was Decedent of Hispanic Origin? (S		U.S.A.  14. Race - American Indian,
	fter d	Fu	1 Never Married 2 XMarried	1 ☐ Yes 2 📉 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
936	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
Maryland 21215-0036	filed within 72 hours after Hygiene. other than "natural", or Ite ant, the Medical Examina	Completed	15. Decedent's Educa (Specify only highest grade	ation 16a. Dece	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rkina	b. Kind of Business/Industry
7	han a Me	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		-	Harry Diamond
2	Hygien Hygien Ther th		17. Father's Name (First, Middle, Last)	Secu	rity & Procuremen	t Officier me (First, Middle, Mai	
anc	Mental H arked ot atic ever	Be		Price Jones		Edith Thom	
Z	2 should be filed within 72 hours after death with the Manyian and Mental Hyglene is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 20a or 28a-f show aumatic event, the Madisal Examinar must be notified at	ို	Gwilym Lewelyn  19a. Informant's Name/Relationship (Type				City or Town, State, Zip Code) 20871
S	s 1 and 2 should I Health and Men item 27 is marke othar traumatic		Darleen L. Jones		09 Timber Creek L		
Baltimore,	of Health item 27		20a. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State
Ē	Pages nent of ant: If it		1 ♣ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Department 5 ☐ Other (Specify)	Clarksbu	rg Meth. Cemetery	5/2/04	Clarksburg, Maryland
alti	permit. Pages Department of t important: If ite any injury or of		21. Signature of Fune al Service kisensee	// / /	2. Name and Address of Facility Olin L. Molesworth	n P.A., Fii:	neral Home
_	2012 20	7, 1	hovert L.	Williams	26401 Ridge Road,	Damascus,	Maryland 20872-0117
		gr .	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not en cause on each line.	ter the mode of dying, such as cardia	c or respiratory arrest	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Arthy thursa			1 hour
16 <sup>2</sup>	/Medical Examiner		Todaling in doding	Due to (or as consequence of):			
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncoming Cause (Disease or injury that initiated events				
ó	ite be executed sysician and ne burial-transit		resulting in death) Last	Due to (or as a consequence of):			
3760,	ate be nysicia he bu	icai	d.				
<b>68</b>	The law requires that the death certificate I tel has been signed by the attending physionage 2 should be detached for use as the tel	by Physician/Medi	IF FEMALE:				
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery  Month Day Year
0	the a	ysic	1 ☐ Yes 2 ⊡ No 9 ☐ Unknown	4 Pregnant at time of death 5 [ 9 Unknown	Other (specify)		
۵.	that the death ned by the atter detached for u	h h	Part II. Other significant conditions cont	inbuting to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ds,	w requires that s been signed to should be det	d b	Normal por	erque hydr	ocephalus	1 🗌 Yes	2 No 3 Probably 4 Unknown
of Vital Record	s beer	Completed	L	6	C	24a. Was an	24b. Were autopsy findings available
Re	The la	E				autopsy performe 1 Yes 2	
ita	ian: rtifica	0	25. Was case referred to medical		26. Place of De	ath (Check only one)	
1	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatien	nt 3□ DOA Other: 4□ Nursing H	Home 5 Mesidend	ce 6 Other (Specify)
o u	ng Pt fter th		27. Mann of Death  1 Matural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred
sio	Attending or death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	ORA Landing (Charles	at and Mirmhau as Dural Courts Mirmhau
Division	i or Att after d Direct	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2		29a, Certifier 1 Certifying Physi	icien: To the best of my knowledge, deat	th occurred at the time, date and place	e, and due to the caus	se(s) and manner as stated.
	24 hr e Fun etely	edical		er: On the basis of examination and/or in and manner stated.			
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	A Ro	29c. License number		. Date signed (Month, Day, Year)
•			1 Sursa	X WV	17380	76 L	pr.1292004
	5		30. Name and address of person who con	npleted cause of death (Item 23a) (Type	, Print)	(	,
	)		Leonard Sax, M.I		Avenue - Suite J,	Poolesvi	lle, Maryland 20837
	St	ate	31. Date filed (Month, Day, Year)	32. Registraris Signature	A door V.		

			For Stata Ragistrar	State of Ma	aryland / D	epartment Certificate	of Healt of Dea	th and Mer ath		iene 2001 <sup>99. No.</sup>	15870			
ı			1. Decedent's Name (First, Middle,	Last)					Date of Deat Month		3. Time of Death			
	Physici: /Medic		Jay	Alan		Kepha	irt	A		30 Joo	1 21:47 M			
	Examin		4a. Facility Name (If not institution,	give street and number)			own, or Locat	tion of Death		4c. County of Deat	th			
	Examin	•	Washington Cour	ty Hospital		Hager	stown			Washing	ton			
	Funeral				e (In yrs. last birth	day) If Under 1	Year If Ur	nder 24 Hrs. 8.	Date of Birth	Q Rin	holage (State or Foreign			
	Director		220-54-4749	1 <b>X</b> M 2□F	51 Y	rs. Months	Days Hou	urs Min. Ma	(Month, Day,	),1953 Mary	vland			
			Usual Residence of Decedent											
	/lanc		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits			
	Man,	ξ	Ohio Warren		Lovelan	d					1∏Yes 2 ☐ No			
	the 286	Director	10e, Street and Number			10f. Zip C	Code		10	Og. Citizen of What Co	ountry?			
	with with		9651 Dartmouth	Marr		451	40			U.S.A.				
	s 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.			c Origin? (Specify	Yes or No-	14. Race - Ame	nican Indian			
	lten d	5	1 Never Married 2 Marrie	Armed Forces?				c Origin? (Specify xican, Puerto Rica	an, etc.)	Black, White				
က္ခ	rs afi	by F	3 ☐ Widowed 4 1 Divorced	If Yes, Give Year or Dates:	140	1 ☐ Yes 2	No Spe	ecify:		Specify: Whi	ite			
3	hou ture		15. Decedent's		16a I	Decedent's Usual	Occupation			16b. Kind of Business/				
Ċ	"na	Completed	(Specify only highest	grade completed)		(Give kind of work life. DO NOT use	done durina.	most of working		TOD. THING OF EGSHOOS	modstry			
2	withi ane. Ithen	m	Elementary/Secondary (0-12)	College (1-4or	5+}	les	, , , , , , , , , , , , , , , , , , , ,		, n	Machine Too	ol & Die			
N .	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or items 23a or 28e-f show svent, the Medicul Ena " it at traist ke notified at		17. Father's Name (First, Middle, L	ast)			18 M	Nother's Name (Fi			<u> </u>			
ב	be f	Be	Jack C. Kephart					nevieve		_ /				
Ž	i Mei Mark nark	10			101									
Maryland 21215-0036	pes 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 Is marked other then br other traumatic svent, the Me		19a. Informant's Name/Relationsh Tara D. Kephart/			-		imperor Hurar Ho Cincinnat		City or Town, State, 2	Lip Code)			
	and health m 27					T 01-11								
0	Jes 1 If ite		20a. Method of Disposition 1 ☐ Burial 2 【XCremation	3 □Removal from State	cemetery	Disposition (Name r, crematory or oth	er place)	Date		20c. Location - City or				
Ξ	Pages ment of ant: If it ury or o		`4 □ Donation 5 □ Other (Sp		Smiths		_	5/3/200		Smithsburg,				
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L	icensee	Facility Rest	Haven	Funeral Ch	napel						
n	90 E 9 9		Stephen M.	Sums		1601 Pe	nnsy1v	ania Ave	. Hage	rstown MD	21742			
г			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused	d the death. Do no	ot enter the mode	of dying, such	h as cardiac or re	spiratory arre	est,	Approximate Interval Between			
	Physician		Immediate Cause (Final		F .	io.					Onset and Death			
	/Medical		disease or condition resulting in death)	a. Liver	a consequence of						Tyear			
	Examiner			b_alcot	•						Years			
	T.N.	e	Sequentially list conditions, if any, leading to immediate		a consequence of	f):				10013				
	petr Insit	ᇤ	Cause (Disease or injury											
	al-tra	Examine	that initiated events resulting in death) Last	c Due to (or as	a consequence of	f):								
8760	death certificate be executed e attending physician and of for use as the burial-transit													
8	icate phys	dical		0.										
×	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					33d Date of doll	i von			
Box	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 Ectopic pred				23d. Date of deli Month	Day Year			
o.	at the de by the a tached	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time or death	5 Other (spec	CIIY)							
a.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ns contributing to death b	out not resulting in	the underlying car	use given in P	Part I	23e Did tob	acco use contribute to	the cause of death?			
Division of Vital Records,	ires that signed t I be det	by	Renal Failu				girai, iiri				obably 4 Unknown			
5	w require been sig should b	Completed								2210				
ec	las b	ple	Gastroinkot	rnal Ble	eding				24a. Was ar autopsy	prior to d	topsy findings available completion of cause of			
r	The tav cate has page 2	Con	Preumonia		J				perform 1 ☐ Yes 2	ied? death? ☑No 1☐Yes	2 No			
<u>ta</u>	icien: Th certificate rector, pag	Be (	25. Was case referred to medical				26. F	Place of Death (Cl	heck only one	)				
>	Physic this ceral direct	ToE	examiner/ 1   Yes 2 1 No											
0	g Ph ier th													
Ö	tending I leath. tor: After the funer	atlo	2 Accident investig		,	M	1 Tes	2 No						
N S	Atte	ific	3 ☐ Suicide 6 ☐ Could not determine	288. Place of In	jury - At home, fari c. (Specify)	m, street, factory,	office	28f.	Location (Str City or Town	eet and Number or Ru	ral Route Number,			
	el or At s after d il Direct sd in by	Certification:		ballaling, et	o. (opoury)				Jay or TOWIT	, 5.4.0/				
	Spit hours iners / fille		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge,	death occurred at	t the time, dat	te and place, and	due to the ca	use(s) and manner as	stated.			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	edical												
	To the within To the To the To the To the Tomp	Me	29b. Signature and title of certifier			29c.	License numb	ber	29	d. Date signed (Month	n, Day, Year)			
			Danthia K	uttree - Sar	do mp	D	4745	5/	1	lay 1, 20	04			
	10		30. Name and address of person v	who completed cause of a	death (Item 23a)	Type, Print) -	01	-1 D 1	Non	encta	Manula			
1	SH- 1-		Chatha Kutta	r-Sands M	D 14214	Paradis	sechu	rch Koad	mag	2176	ruryland			
6	Sta	te	31. Date filed (Month, Pay, Year)	32. Begisti	ar's Signature	Bracket				41/12				
	Regist	ar	29b. Signature and title of certifier  Cynthea K  30. Name and address of person of the control	2004 Meele	10 15° 1									

The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, the attending physician signed by rs after deau. rel Director: After this cerm. Hospital or Attending Physician: within 24 hours a To the Funeral D

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Modical Exerciting at Appre.

**Physician** 

/Medical

**Examiner** 

as the burial-transi

pinous

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

State

Registrar

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

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200Ks/

hours

APR 2 6 2004

			For State Registrar	State of Maryland / Dep Ce	partment of Health and ertificate of Death	Mental Hygier Reg. t	
	Physici		1. Decedent's Name (First, Middle, La	WESLEY KIR	K	2. Date of Death Month APRIL Z	Day Year 3. Time of Death
	/Medio Examir Funeral		Social Security Number 6.5	R HOSPITAL CENTER		. 8. Date of Birth	4c. County of Death  COUNTY  9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	10XM 2□F 93 Yrs.		June 3, 19	910 Maryland
	the Marylar 28a-f show notified ut	rector	MD Kent  10a. State 10b. County  MD Kent	10c. City, Town or I	10f. Zip Code	10g. (	10d. Inside City Limits 1 ☐ Yes 2♥ No  Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importents: If item 27 is marked other then "naturel", or Items 23a or 28a-f show spirity or other treumatic event, I're Medical Evanfrar must be routified ut once.	by Funeral Director	11200 Green COVe  11. Marital Status  1 Never Married 2 Married  3 Millowed 4 Divorced		21661 3. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 □ No Specify:	Specify Yes or No- to Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	e filed within 72 hour al Hygiene. I other then "naturel vent, the Medical Ex	Completed b	15. Decedent's E (Specify only highest gr.	iducation ade completed) 16a. Dec (Giv. life.	cedent's Usual Occupation we kind of work done during most of wo DO NOT use retired)	rking	Kind of Business/Industry
Maryland 2	should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last William Wesley I	o Kirk	18. Mother's Na Eva Br	me (First, Middle, Maid ickey	en Sumame)
	ges 1 and 2 she it of Health and if item 27 Is m or other treum		19a. Informant's Name/Relationship ( William W. Kirk  20a. Method of Disposition 1X Burial 2 □ Cremation 3 □	III 6017  20b. Place of Disconnectory, cr	illing Address (Street and Number or R 7 Fairfield Lane, position (Name of rematory or other place)	Eldersburg	MD 21784 Location - City or Town, State
Baltimore,	permit. Pages Department of I Importent: If ite eny injury or of 2009.		1 Donation 5 Other (Special Signature of Funeral Service Lice	nsee	Valley Memorial 4 22 Name and Address of Facility ellows, Helfenbei 30 Speer Rd. Ches	n & Morrom	ockeysville, MD Funeral Home, P.A. 21620
	Pnysician /Medical Examiner	2	23a 741. Enter the disease, or commond, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. Do not er one cause on each line.  The wmn/a  Due to (or as a consequence of):	onter the mode of dying, such as cardia  Organism ande	c or respiratory arrest,	Approximate Interval Between Onset and Death  2 2 4 cys
68760,	icate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, backing to manufacture cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):			
P.O. Box 687	law requires that the death certificate as been signed by the attending phys should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	quires that n signed by uld be deta	þ	Renal Failu	contributing to death but not resulting in the	on/C		o use contribute to the cause of death?  2 Xo 3 Probably 4 Dunknown
of Vital Records,	o _ c @	Completed	Prostate Co	incerwith bong me +		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
f Vita	Physicien: Th this certificate ral director, pag	To Be (	25. Was case referred to medical examiner? 1 \( \subseteq \text{Yes}  2 \subseteq \text{Yeo} \)	Hospital: 1 → patient 2 □ ER/Outpati	Othor	ath (Check only one)  Home 5 - Residence	6 □Other (Specify)
Division c	or Attending tter death. irector: After n by the fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not to determined	De 280 Place of Injury - At home form	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in 28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	ledical Ce		hysician: To the best of my knowledge, de- iminer: On the basis of examination and/or and manner stated.			
	To th within To th compl	Me	29b. Signature and title of certifier  Sum K. R	' בע אי בע א	29c. License number	Md. 4	Date signed (Month, Day, Year)
			Jusan K. Ross, m.	o completed cause of death (Item 23a) (Typ)  514 Washington Ar	04	id-21620	,
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sacrette in		

			. For		Maryland / D					-		001	15071
			1 - State Registrar		(	Certifica	ite of l	Death			Reg. No.	004	128/4
	Physici	an	Decedent's Name (First, Middle, Inc.)							2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin		Barry Edward  4a. Facility Name (If not institution, g		r)	4b. Ci	y, Town, or	Location o	of Death	May 2	2004 4c. Cou	inty of Deat	12:00 A M
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	Funeral		Social Security Number 6		Age (In yrs. last birtl	rs. If Uni	er 1 Year s Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, De Sept. 2	rth ay, Year)	9. Birtl	hplace (State or Foreign untry)
	Director		218-34-3604 Usual Residence of Decedent		/3 '	13.				Sept. 2	20, 1920	o Mai	ryland
	nyland how	_	10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Ba-f s	ecto	J	erick	Frede						10 011	())	1 Yes 2 No
	within 72 hours after death with the Maryland ane. than "natural", or liems 23a or 28a-f show ta Medical Examinat nat Le notified at	Funeral Director	10e. Street and Number 9044 Bethel Road				Zip Code 1702				10g. Citizen United		
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9	or Ite	/Fui	1 X Never Married 2 ☐ Married	Armed Force 1 XYes 2 [ If Yes, Give Year or Dates	]No 1951_		2XX No		i, Puerto i	rucan, etc.)		Black, White Bo <i>ify:</i> White	
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and	be file	Be	17. Father's Name (First, Middle, La Raymond Ira Keys							(First, Middle		name)	
Maryland	shoutd nd Men marke umatic	우	19a. Informant's Name/Relationship		19b.	Mailing Addre	ss (Street			Harle		wn. State. Z	Zip Code)
	alth and 27 is my rtraum		Alton R. Keyser							erick,			
ore,	of Hea fitam		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3		20b. Place of		lame of			'2004	20c. Location	on - City or	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant. It a Medical Examination at a collidation.		'4 □ Donation 5 □ Other (Spe	city)	Resthar			- 1					Maryland
Bal	permit. Departr Imports any inj		1916	21. Signature of Fun ral Service Licensee  22. Name and Address of Facility Resthaven Funeral Service 9501 Catoctin Mtn. Hwy.									
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	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	With the second	rastry	tai	We						
	Examiner			SQUA	as a consequence of	1): i( Ca	ncer	a F	Lon	lyax			
	P =	ner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	U. The second	as a consequence o	f).			-	(			
	and -trans	xami	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence o	f)·							
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	res that t igned by be detac		Part II. Other significant condition	s contributing to death	but not resulting in	the underlyin	g cause give	en in Part I.		23e. Did	tobacco use c	ontribute to	the cause of death?
rds	w requires been sig should be	ed b	CCPD							12	es 2□No	3 □ Pro	obably 4 (Unknown
Records,	law re las be	Completed by								24a. Was	psv	prior to c	topsy findings available completion of cause of
a H										1 Yes	2 No	death?	2/21/10
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{Yo} \)	Hospital:	atient 2 ☐ ER/Out	patient 3	Othe	25		<i>(Check only</i> ine 5 ☐ Resi		Other (Spec	nific)
) of		<del> </del>	27. Manner of Death	28a. Date of Ir	jury 28b. T		28c. Injun	at at	-	28d. Describe			ony)
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Division	s after d	Certifi	3 Suicide 6 Could no 4 Homicide determin	200. Flace of	Injury - At home, far etc. <i>(Specify)</i>	m, street, faci	ory, office		2	28f. Location ( City or To		ımber or Ru	ral Route Number,
	To the Hospital or Attandil within 24 hours after death. To the Funeral Diractor; A completely filled in by the fu	Medical Certification:	29a. Certifier Certifying (Check only one)	Physicien: To the be aminer: On the basis and manner	of examination and	death occurr /or investigat	ed at the tin	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	Dave Do	PRINODOC ICCS PTTE 1		29c. License		953		29d. Date sig	ned (Month	n, Day, Year)
IV	A		30. Name and address of person with the state of the stat	Denicl	f death (Item 23a) (	Type Print)					1, ND	217	ė i
\$5	Sta Regist		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	6	de	Parks	/				
				/									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2 \left( \begin{array}{c} 1 \\ 1 \end{array} \right) \left( \begin{array}{c} 1 \\ 1 \end{array} \right)$ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year JOHN CHARLES LAUGHLAND May 2004 5:30 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Sept. 5, 10 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 1**√** M 2□ F 106-28-8479 67 Canada Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Frederick Maryland Frederick 10e. Street and Number 8329 Ball Road 10g. Citizen of What Country? 10f. Zip Code 21704 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2√7 No If Yes, Give \( \text{\text{\text{\text{\$\tex{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitit{\$\text{\$\text{\$\texi}}\$}}}\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\te 1 Never Married 2 7 Morried
3 Widowed 4 Divorced 1 ☐ Yes 2√2 No Specify: If Yes, Give Year or Dates: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Civil Engineer <u>Engineering Firm</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milton Laughland Norah O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie W. Laughland/Wife 8329 Ball Road, Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mount Olivet Cemetery May 10, 2004 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Frederick, Marylan 21. Signal of Funeral Service Licensee 22. Name and Address of Facility Cillian Keeney & Basford Funeral Home 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21701
Approximate
Interval Between
Onset and Death Immediate Cause (Final TYOCARNIAL HOURS disease or condition resulting in death) Due to (or as a neumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 TYes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

/Medical **Examiner** by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certiticate be executed the burial-transit P.O. Box 68760 Division of Vital Records, director, page 2 should Be Completed Certification; To after death. tilled in 24 hours a Funeral C

**Physician** 

/Medical

**Examiner** 

by Funeral Director

Completed

Be

Funeral

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Pages 1 and 2 should be tiled within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, "the Medical Enaminer must be notified at

permit. Page Department of Important: If any injury or once.

Physician

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death Natural 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

within 2. To the I

Medicai

homas

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rederick MOZITOZ AZITEGAZI

31. Date filed (Month, Day, Yeer)

29b. Signature and title of certifier

MAY 1 8 2004

32. Registrar's Signature

lohuson

DHMH 17 Rev 1/2001

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		_	1 - For State Registrar	State of Ma	arylan		artmen rtificate			and M		Reg. No. 2	004	158	76
	Physici /Medic		Decedent's Name (First, Middle,     Martha	Elizabeth	Le	athern	nan				2. Date of De Month MAY	Day 8 2	Year 2004	3. Time of Di 8:41A	eath M
	Examin	_	4a. Facility Name (If not institution,	- 110					Location o				ty of Death		
	Funeral Director		MEMORIAL HOSPITA 5. Social Security Number 220-16-6562		je (In yrs. 77	last birthday) Yrs.	If Under Months		If Under: Hours		8. Date of Bir (Month, Da NOV 4,		9. Birthp	lace (State or F	-oreign
	Maryland show	or	Usual Residence of Decedent  10a. State 10b. County  MD Alleg	any	10c. City	y, Town or Lo	cation Derlan	d					1	0d. Inside City	
	with the P a or 28e-	Direct	10e. Street and Number 512 Winifred Ro	ad	<u></u>		10f. Zip		21502	)		10g. Citizen of	What Coun	try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hydjene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show styr injury or other traumatic svent, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?			Was Deced f Yes, spec 1 ☐ Yes 2	ent of Hi			ecify Yes or No Rican, etc.)	- 14. Ra	ace - Americ ack, White, ify: white	etc.	
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or :	5+>	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	rk done d	uring most	t of work	ing	16b. Kind of I			
land 2	id be filed lental Hygi ked other lic svent,	To Be Co	17. Father's Name (First, Middle, La Claude Cage	ist)		1			Myr	tle V	(First, Middle, 'irginia (	Maiden Suma Wolfe)	Cage		
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۵.	Se ig	þ	Part II. Other significant condition	s contributing to death b	out not res	ulting in the u	nderlying c	ause give	n in Part I.			obacco use cor res 2 \( \subseteq \text{No} \)			
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				tate of Maryland / (			ntal Hygiene	2004	12811
			_ State Registrar		Certificate of	Death	Reg. No	·	
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	Funeral Director		5. Social Security Number 6. Sex 12 4-26-3 88/	7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	(Month, Day, Year)		ace (State or Foreign ry)
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ē,	ss 1 and 2 of Health item 27 I		20a. Method of Disposition	20b. Place o	f Disposition (Name of ry, crematory or other place	Date	9 20c. Lo	ocation - City or Tov	
<u>E</u>	Page nent c ant: If ury or		1.	oval from State	Meth. Ch. Ce	m. May 4.	2004 Rock	relle, l	A
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show amportent: are interest traumatic event, the Modical Execution Liver in a like notified at any injury or other traumatic event, the Modical Execution Liver in a like notified at any injury or other traumatic event, the Modical Execution Liver in the notified at any injury or other traumatic event, the Modical Execution Liver in the notified at any injury or other traumatic event, the Modical Execution Liver in the notified at any injury or other traumatic events.	1	21. Signature of Funeral Service Licensee	dyd cco204	Preday Fun	ss of Facility 5-	9 Edgew Madis	ood School	
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Ö	v requ been shouk	etec	- Mypertension	TOPACE CO			24a. Was an		sy findings available
Vital Records,	The lay	Completed					autopsy performed?	prior to com death?	pletion of cause of
ta		0	25. Was case referred to medical			26. Place of Death (C	1 No 2 es 2 □ No 2 heck only one)	1 ☐ Yes	No
Ž	Physicien: this certific ral director,	To B	examiner?	ital: Inpatient 2 ER/Ou	itpatient 3 DOA Oth	Or:	5 Residence	6 □Other (Specify)	
n of	ng fter		27. Manner of Death  1 Natural 5 Pending		Time of 28c. Injur		f. Describe how injur	y occurred	
Division	Attending in death.  actor: After by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home, fa		Yes 2 □ No	. Location (Street an	ed Numbos os Russi	Pouto Alumbor
Σ	after after Dirac	ertif	4 Homicide determined	building, etc. (Specify)	im, street, factory, onice	201.	City or Town, State		rioute reuniber,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) Certifying Physicia	in: To the best of my knowledge On the basis of examination ar and manner stated.	e, death occurred at the tindor investigation, in my o	ne, date and place, and pinion, death occurred	I due to the cause(s) at the time, date and	and manner as sta place, and due to	ited. the cause(s)
	ro the	Me	29b. Signatur and title of cert fer	ı la	29c. Licens	e number		te signed (Month, D	
	,- ,- 0		I comes I We		Res.	-000	Apr	11501	4007
	12		30. Name and address of person who comp	eted cause of death (Item 23a)	(Type, Print)		1.	170	
	10		James Sun De Merst 31. Date filed (Month, Day, Year)	er 600 N. 32 Registrar's Signature	with Walte	Street, Bo	altemore,	MD 515	87-9106
	Sta Regist		MAY 1 8 2004	Sz. Hegistrar's Signature	(Type, Print) with Walfe	2			
					-Je - Carelon				

			Plea		•		nd / Depa	artmen	t of F	. Assure A lealth and I Death	•	/giene	0001	<b>,</b>	O 1001
	Physici	an	Decedent's Name (First, Middle Elva Jane Lashley				Cei	TIIICAT	e oi	Deam	2. Date of D Month		2004	3. Time of D 01:10 PN	
>	/Medio Examir		4a. Facility Name (If not institution	, give stre						4b. City, Town, or I		th 4c. Co	ounty of Death		
Ī	Funeral Director		Frostburg Village N 5. Social Security Number 217-54-6453	6. Sex	.~ 7.		. last birthday) Yrs.	If Under Months	l l	If Under 24 Hrs. Hours Min.	8. Date of B		9. Birth	place (State or I ntry) nsylvania	
	Maryland e-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Alle	gany			ity, Town or Lo unt Sava							10d. Inside City	
	ath with the 23e or 28	rai Director	10e. Street and Number 1291					10f. Zip	45-			U.S.A.	n of What Cou		
5-0020	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or ttems 23e or 28e-f ehow ent, The Medical Evaniner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 X Widowed 4 □ Divorced	ied	Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es? No		Was Deced fYes, spec I□Yes 2	-	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		Race - Amer Black, White Decify: White	etc.	
0-61212	within 72 ho ene. then "netur	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade co	on ompleted) College (1-4	or 5+)	16a. Deced (Give life. I	lent's Usua kind of wor DO NOT us	I Occup rk done se retire	pation during most of wor d)	king	16b. Kind	of Business/Ir	ndustry	
yland	ev ev	To Be Co	17. Father's Name (First, Middle, Henry E. Baker	Last)						18. Mother's Nan Elsie Hoel	nshel				
e, Mar	1 and 2 Health a sm 27 is		19a. Informant's Name/Relationsl  T. Kay Ryan  20a. Method of Disposition	nip <i>(Type</i> ,	Print) daugh	20b.	Place of Dispo	sition (Nam	ne of		ral Route Numb tburg Date	///	own, State, Zi aryland tion - City or T	21332	
altimore,	t. Page rtment o rtant: If i		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St  21. Signature of Euneral Service to	pecify)	oval from Sta		cemetery, cren Savage M	ethodis	t Cer	netery 26-	Apr-2004				
ă	permi Depa Impor eny ir		23a Part Enter the disease or	Complicati	ons that cau	sed the dea				Home, 57 F			rg, MD	21532 Approximate	
	Physician /Medical Examiner		23a. Part. Enter the disease, or mock, or heart failure. List  Immediate Cause (Final disease or condition resulting in death)										-	Onset and De	ath
	be executed cian and burial-trensit	Examiner	Sequentially list conditions,	<b>6</b>	Cor	Due to (	or as a consequence or as a consequence of the cons	uence of):  Acry  uence of):	G	u In L'sease	1		1	48ho years	
68/60		70	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		Due to (d	or as a conseq	uence of):	٠						
.O. Box	the d	Physician/Medic	Part II. Other significant conditio	d	uting to deat	h but not res	sulting in the ur	nderlying ca	ause giv	en in Part I.		tobacco usa Yea 2□ I		otha cause of o	
cords, r	w requires that s been signed b s should be deta	þ									24a. Was	an autopsy ormed?	24b. W	ara autopsy find allable prior to empletion of cau	dings
H H	The la ate has page 2	e Completed	25. Was case referred to medical							26. Place of Dea	1 D		of	déath? □Yes 2□ No	
IN OF VI	To the Hospital or Attending Physicien: within 24 hours lefter death.  To the Funerel Director: After this certification is a second to the funerel director, when the funeral director, completely filled in by the funeral director,	To B	examiner? 1   Yes 2   No  27. Manner of Death   Natural 5   Pending		oital: 1 □ Inp 28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury	28	Bc. Injur Wor	er: 4 Nursing Hoy at k?	ome 5 Res 28d. Describe	dence 6 🗆		(y)	
DIVISION	al or Attend s efter death I Director: /	Certification:	2  Accident investig 3  Suicide 6  Could r 4  Homicide determi	ot be	8e. Place of building,	Injury - At h etc. (Speci	nome, farm, stre	M eet, factory		Yes 2□No		Street and N wn, State)	lumber or Run	al Route Numbe	or,
	the Hospite in 24 hours the Funere	edicai	(Check only 2 Madical i			s of examina	ation and/or inv	estigation,	in my o	ne, date and place, pinion, death occur	red et the time,	date and pla	ace, and due t	o the ceuse(s)	
•	<b>2</b> ₹ <b>2</b> 000	M	29b. Signature and title of certifier	(m	~	)		290	Licens	onumber		290. Date s	igned (Month,	12004	+
,	nls		30. Name and address of person of Jesus Tan	M.1	D. Fr	ostho	m 23a) (Type, 1	Print) AZA	P	rostbu	rg, M	arylan	nd 21	532	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 200	)4	82. Reg	istrar's Signi	atura	park	2			,			

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vaar Clara Elizabeth Low April 4:30 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Manor Chestertown

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Kent 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 103 217-03-2872 1900 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2 X No MD Kent. Chestertown Direct the 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 10589 Colfax Road death Completed by Funeral **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3. Widowed 4 □ Divorced Specify: White natural'. Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natury or other traumatic event, the Mudical ury or other traumatic event. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4-5 Packer Packing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ John Latham Sally (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Ann Anderson/granddaughter 10589 Colfax Road, Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chester Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Apr 26, 2004 Chestertown, MD 21. Signature of Funeral Service Licensee Fellows Helfenbein & Newnam Funeral Home PA Kink 130 Speer Road, Chestertown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a confinence of): Physician disease or condition resulting in death) week /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Living Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21313 MD. 164/Men. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 415 Washington Ave, Chestertown, MD 21620 KIN K. WUN,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year **Physician** 6:00 PM Kay Yoshiko Luckow May 2004 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 8010 Meadowview Drive Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 25, 1929 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2 F Deys 75 Yrs. 536-68-0462 Director Japan Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8010 Meadowview Drive 21702 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Yes 21 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XX No Specify: Asian Be Completed by ii 1es, Give Year or Dates: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If item 27 is marked other any injury or other traumatic event Yasaburo Katsurayama Isa Hiyasaki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Kenneth Luckow / Husband 8010 Meadowview Drive, Frederick, MD 21702 May 5, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2004 Resthaven Crematory Frederick, Maryland 22. Name and Address of Fecility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Service Licenses 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) months **Examiner** Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Pulmonar 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 17 PAOSIR Emphysema 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Menner of Deeth 28b. Time of Injury 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier TOT ohen 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) D. S COTT Cohen MD 5530 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 6 2004 Registrar

	).		1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment o	f Health and of Death	Mental Hy	ygiene Reg. No. 2	004	1588
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last     George Thomas McM     4a. Facility Name (If not institution, give	ullen street and number)		′	n, or Location of Dea	2. Date of D Month May	06, 4c. Cou	nty of Death	3. Time of Death 6:30 a. M
	Funeral Director		Clearview Nursing 5. Social Security Number 6. Security Number 219-01-6640 Usual Residence of Decedent		last birthday) 88 Yrs.	Hager If Under 1 Ye Months Da	ear If Under 24 Hr	n. (Month, D			ace (State or Foreign try)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Exertities main be notified at once.	To Be Completed by Funeral Director	10a. State MD Washingt.  10e. Street and Number  14530 Tollgate Rid  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 8  17. Father's Name (First, Middle, Last) Joseph Allen McMul 19a. Informant's Name/Relationship (T) David A. McMullen/ 20a. Method of Disposition 1 Burial 2 McCremation 3 F 4 Donation 5 Other (Specify)	DOD    Color	16a. Dece (Give life) Truck 19b. Mailir 14530 Place of Dispo cemetery, cren ithsbur	Andress (Str.)  Toll: Stion (Name of natory or other). Name and Ad	of Hispanic Origin? (Cuban, Mexican, Pue No Specify: Coupation and during most of witired)  18. Mother's Na Emaline eet and Number or Fate Ridge	orking  Ame (First, Middle  Philes  Rural Route Numb  Hancock  Date  09/04	USA lo- lo- lo- lo- lo- lo- lo- lo- lo- lo-	of What Count  tace - America  Slack, White, e  city: Whi  Business/Ind  Govern  ame)  wn, State, Zip (  50  n - City or Tow	an Indian, tte  ustry  ment  Code)  wn, State  II)  Street
68760,0	death certificate be executed  Washington and earthending physician and for use as the burial-transit	Jedical Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	ne-cause on each line.	uence of):		Caush				Approximate Interval Between Onset and Death
ds, P.O. Box	ires that the death certific: signed by the attending pl 1 be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions con	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3□ eath 5□	Ectopic pregna Other (specify, iderlying cause	)		tobacco use co	ntribute to the	y Year Year cause of death?
Vital Records,	iician: The law requires that the certificate has been signed by th rector, page 2 should be detache	e Completed	Cerubo Varall  25. Was case referred to medical	an Accide	~	7 100		24a. Was auto perfo 1 🗆 Yes	san 24t psy ormed? 2 2 No	. Were autops	sy findings available pletion of cause of
Division of Vil	ling Phys  After this luneral di	Certification: To Be	eyaminer?	lospital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In V M 1	Other: 4 Aursing I nury at Vork? Yes 2 No	28d. Describe	idence 6 🗆 O	urred	
N	Hospital or 4 hours afte Funaral Dir iely filled in i	edical Certifi	4 Homicide determined  29a. Certifier 1 Certifying Physics	28e. Place of Injury - At he building, etc. (Specify sician: To the best of my knoner: On the basis of examinal and manner stated.	v) wledge, death	occurred at the	time date and place	28f. Location ( City or To	wn, State)	nannar as stat	nd
	To the within 2 To the complete	Mec	29b. Signature and title of certifier  30. Name and address of person who co	and manner stated.		29c. Lice	ense number		29d. Date sign	ed (Month, Da	ay, Year)
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	,	HARERS	rown	m0 2	.1740	

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سور			1 - For State Registrar  1. Decedent's Name (First, Middle, Last	State of Marylan		artmer rtificat					Reg. No.	2004	3. Time o	882
	Physici /Medic Examin	al		SE MOYERS, JR	•	4b. City,	Town, or	Location o	]]	Month MAY	Day 4	Year 2004 County of Deat	7:10	P M
A	Funeral Director		215 58 6936		last birthday) Yrs.		VALE 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da NOV 27	th ly, Year)	Co	nplace (State ountry) YLAND	or Foreign
	h the Maryland r 28a-f ehow notified at	Director	Usual Residence of Decedent		y, Town or Lo	ocation 10f. Zip	) Code				10g. Citi	zen of What Co		ity Limits
5-0036	be filed within 72 hours after death with the Maryland at Hygiene, and Hygiene, of chart hen "natural", or itema 23a or 28a-f ehow other then "natural", or itema 23a or 28a-f ehow event, the Medical Exam natural be notified at	by Funerai	819 REAR NATIO  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	NAL HIGHWAY  12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:				spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	cify Yes or No Rican, etc.)	U.S.	14. Race - Ame Black, White		
2121	filed within Hygiene. other then ent, the Me	e Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 1 2  17. Father's Name (First, Middle, Last)		life.	dent's Usu kind of wo DO NOT u	rk done d se retired,	uring most		g (First, Middle,	CAR	DEALERS Sumame)	,	
Maryland	2 should and Mer le marke aumatic	To B	RAYMOND JESSE  19a. Informant's Name/Relationship (7) SUSAN MOYERS / WIF	ype, Print)				nd Numbe	r or Rural		er, City o	Town, State, Z		
Baltimore, I	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr once.		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Removal from State THE	Place of Disponentery, cremeter, cremetery, cremeter,	sition (Nai natory or o RLANI . Name ar	me of other place  CRE	MATOR	Da .Y 5/.	5/04 (	20c. Lo CUMB 1 60 W .	Cation - City or TERLAND, MAIN S	MD STREET	
8760,	death certificate be executed  Medical  Madical  Medical  Madical  Medical   dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ne cause on each line.	MALC uence of):							NG	Approximat Interval Bet Onset and I	ween	
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ō	ding Phys h. After this funeral di	은	27. Manner of Death  1  Netural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpatient 2 Month, Day Year)	ER/Outpation 28b. Time of Injury		8c, Injury Work	7 . 101	28	e 5 Resident		Other (Special occurred	ify)	
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7	2 × 2 0	~	29b. Signature and little of certifier	M		290	C. License	133)	71			signed (Month)		
	Sta	to.	31. Date filed (Month, Day, Year)	ompleted cause of death (ken	. 624	Print Ke	ntf	₩P., (	lun	berla	and,	E am	2150	2
	Sta Registr		MAY 1 8 2004	Denva ,	5 1	pour	21							

		-	For State Registrar	S	tate of	Marylar		artment tificate			and M	ental Hy	gienę. Reg. No.	7 11 11 11	+	15883
	Dhusiais		1. Decedent's Name (First, Middle	, Last)								2. Date of De Month	ath Day	Ye	ar	3. Time of Death
	Physicia Medic/		HELEN LO	OUISE	M]	ILLER						April	27	2004		5:30 p.m.
	Examin	er	4a. Facility Name (If not institution	, give stree	et and numb	ber)		4b. City, T	Town, or	Location of	of Death			County of D		
			106-19 Bayland			//	/	Havre If Under 1		race	24 Hrs	D D		arford		
	uneral		5. Social Security Number	6. Sex 1 ☐ M		. Age (In yrs.	Yrs.		Days	Hours	Min.	8. Date of Bird (Month, De	y, Year)		Count	.,
DI	irector	-	214-09-9333 Usual Residence of Decedent		Λ	90						Feb. 2	1 19.	14 Ma	ıryl	and
land	No TH		10a. State 10b. County			10c. Cit	ty, Town or Lo	cation							10	d. Inside City Limits
Man	투표	ģ	Maryland Harfo	rd			HavreD	eGrace	е						ŀ	1 X Yes 2 □ No
h the	128	i e	10e. Street and Number		-			10f. Zip (	Code				10g. Citiz	zen of What	Count	y?
E K	23a o	a	106-19 Bayland	Driv	e				210	78			II.S.	. A .		
990	SE S	Funeral Director	11. Marital Status	12.	Was Deced	ent Ever in U	.S. 13. V	Vas Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	. 1	14. Rece - A Black, W		
after a	P H	교	1 Never Married 2 Marr	ied '	I □Yes 2 If Yes, Give	. ☑ No		I□Yes 2		Specify:	,	, , , , , ,		Specify:		
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2121 ad within	than E M	E	Elementary/Secondary (0-12)		College (1-4	tor 5+)		ecreta					(	Colleg	10	
E P	ont.		17. Father's Name (First, Middle,	Last)			J.,	ecrete		18. Mothe	r's Name	(First, Middle,			<u> </u>	
and be entail	ked o	To Be	Vernon Monroe	Milla	r					Ir	ene :	Elva Mi	11er			
Maryland 2121 d 2 should be filed within 1 th and Mental Hygiene.	mar	F .	19a. Informant's Name/Relations				19b. Mailin	g Address (	(Street a	nd Numbe	r or Aura	/ Route Numbe	r, City or	Town, State	e, Zip C	Code)
NG 2 pu	27 is r treu		D.11. A Fal	<b>.</b>	Dauch	t	212 1	Mallar	rd C	ourt	Hav	reDeGr	ace.	Md. 2	107	8
S 1 a	item 27 is marked other than "natural", or items 23s or 28s-1 show other treumatic event, the Medical Examinent, was be inclined at	1	Deborah A. Tob 20a. Method of Disposition		0	20b. F	Place of Dispos	sition (Name	e of			ate		cation - City		
MO Page ent o	7 o #		1 ⊠Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		oval from St	ate	•				Mav 1	2004	Наче	erstow	m.	Maryland
Baltimore,	Importent: If its any injury or o once.		21. Signature of Funeral Service			I		. Name and				nnich				nary rana
ä ää	any ir		I Tred Los	inta	1		4	15 E.	Wil	son E		Hage				1740
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, ,	edical		disease or condition resulting in death)	a	Due to (or	r as a conseq	uence of):	0 030	mer	1	nun	onaly	ons	ian	+	Years
Exa	miner		Cognostially list conditions	b												
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ecute	obysicion and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to /or										_	
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.eate	physics the l	Physician/Medical		d											+	
X 687	attending p	Me	IF FEMALE:	23c.	f ves. outco	ome of pregna	ancv						,	3d. Date of	dalivan	,
B e	atten for u	San	23b. Was decedent pregnant in the past 12 months?		1 Live birt	th 2 ☐ Feta ntattime of d	I death 3	Ectopic pre Other (spe					-	Month		ay Year
P.O.	ched	sk	1		9 Unknow			, O. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	J.,							
	20 U	된	Part II. Other significant condition	ns contrib	uting to dea	th but not res	ulting in the ur	nderlying car	use give	n in Part I.		23e. Did to	bacco us	se contribute	to the	cause of death?
Division of Vital Records, for Attending Physicien: The law requires taffer death.	n sign	d by										1 🕱 🖰	'es 2 □	]No 3□	Probab	oly 4 Unknown
ecor law req	should	Completed										24a. Was	an	24b. Were	autops	y findings available
Re The la	certificate has t lirector, page 2 s	E .										autop perfor	sy med?	prior death	to comp	pletion of cause of
<b>E</b> =	ifficat or, pa	ပ္	25. Was case referred to medica	7.			-			26 Place	of Death	(Check only o	2 No	104	es 2	⊔ No
of Vita Physicien:	s cert	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hosp	ital: 1 □ Inc	patient 2	ER/Outpatient	t 3 🗆 DOA	Otho			ne 5x€ Resid		□Other /S	necify)	
o Ę	eral di		27. Manner of Death		8a. Date of		28b. Time of		c. Injury Work			8d. Describe h			poony)	
Vision Attending	r: After e funera	읉	1 XNaturel 5 ☐ Pendin 2 ☐ Accident investi		(WORL),	Day (Gai)	Injury	М		es 2 □1	No					
ViS Atte	ecto by th		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		8e. Place of	f Injury - At ho	ome, farm, stre	et, factory,	office		2	8f. Location (S City or Tow		Number or	Rural F	Route Number,
S afte	ed in	Certification; To			Danding	, oto. (opcon	,,						n, ciato,			
Divisio  To the Hospitel or Attendit within 24 hours after death.	To the Funeral Director: After this certificate his completely filled in by the funeral director, page	_	29a. Certifier 1 ☑ Certifyir (Check only 2 ☐ Medical	g Physicia	n: To the b	est of my kno	wledge, death	occurred el	t the time	e, date and	d place, a	nd due to the o	ause(s) a	and manner	as stat	ed.
he H in 24	the F	Medical	one)		and manne	r stated.	MINE OF HIV		y op				and and	piavo, allu u		10 00030(3)
Tol	COM	2	29b. Signature and title of certifie					29c.	License	number	0015		29d. Date	signed (Mo	nth, De	ey, Year)
18			1 ) selve	m			1.9.		1)	004	1813		1+0	r.1 6	٥	2004
2	3		30. Name and address of person	who compl	eted cause	of death (Item	n 23a) (Type, f	Print)	6.5-	1.010.	0 = 5	262 7	1	SIA	ir	71) 21014
			31 Date filed (Month Day Vacch	KAR	22 188	A 3 14 Signa	ture up	ser C	usap	year per	0. 7	w. ' = - (1		2001		
	Sta Registra	te ar	29b. Signature and title of certifier  20b. Signature and title of certifier  30. Name and address of person  ASHAC  31. Date filed (Month, Day, Year)  APR 3	2004	32.	GLAN J	B. Sp	all								

State of Maryland / Department of Health and Mental Hygiene 004 1 - State Registrar 15884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Jean McCormick May 04, 2004 2:07A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Egle Nursing Home Lonaconing Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F Yrs. Director 214-07-0941 92 August 29, 1911 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If item 27 le marked other than "natural", or Items 23a or 28a-1 ehow ury or other traumatic event, the Medical Examines must be notified at 10d. Inside City Limits Director 1 MYes 2 No Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 86 East Main Street 21539 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Rubber Tire Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Edward McCormick Agnes Rennie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Smith-Friend 6 Bridge Street Lonaconing Md. 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department ( Important: If any injury or once. May 07, 4 □ Donation 5 □ Other (Specify) Oak Hill Cemetery Lonaconing Maryland 2004 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 E. Main Md 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician erchio Vasculor /Medical Due to (or as a consequence of): Examiner Work atro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗆 No 2**√2** No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification; To 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending death. after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 les40 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) Dection mD, 20 homas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 5 2004 Registrar

			For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	artment of F tificate of	lealth and N Death		iene <sub>eg. No.</sub> 2 (	104	15885
ı	Physicia	an	1. Decedent's Name (First, Middle, Las		. 7	М		2. Date of Death	Dav	Year	3. Time of Death
H	/Medic	al	Dorothy  4a. Facility Name (If not institution, give	Elizah	oetn	Morga	. T or Location of Death	101	24 4c. County	of Death	18:30 M
ı	Examin	er	SACRED HEART	HOSPITAL		Cum	RERLAND		AU	LEGA	NY
I	Funeral Director		5. Social Security Number 6. S		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 36	9. Birthp Coun Mary	lace (State or Foreign try) Land
	and w.		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				1	0d. Inside City Limits
	Maryi I-f sho	to	MD Alleg	any	Cu	ımberland					1 Yes 2 No
	or 288	lrec	10e. Street and Number			10f. Zip Code	<del></del> -	10	0g. Citizen of V	What Coun	try?
	s 23a	rai	14507 Hardman F		11.0	2150		and Vac at No	USA 14 Bac	e · Americ	an Indian
326	n 72 hours after deeth with the Maryland "natural", or Items 23a or 28a-f show edical Exeminat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cub.	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		ck, White,	
215-0036		eted	15. Decedent's Ec	ducation de completed)	(Give	dent's Usual Occup	during most of world	king	16b. Kind of Bu	usiness/Ind	lustry
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ylan	nould be I Mental narkad c	To B	Joseph	Blair		dman	Martha	Jane			augh
Maryland	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Roy R. Morgan, Sr			-	and Number or Ru lan Road,				
altımore,			20a. Method of Disposition 1 ∑ Burial 2 □ Cremation 3 □	Domoval from State		natory or other pla	ce)	l.	20c. Location -		
<u>=</u>	permit. Pages Department of I Important: If it any injury or o		' 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	,,		y UMC Ce		28/2004 'ams Fami	Flint Iv Fun		Home, F.A.
Ba	permi Depa Impo any ir		1. 4 A	Delin 1			ur Street				21502
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	/Medical Examiner		Todaming in dodain)	Due to (or as a conse		mAll	INTES	TIME			4 days
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	ecuter and rrans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. ATHER		EROSI:	5				5 yrs
8760,	icate be executed physician and s the burial-transit	dical E		d DIABE	TES	MELL	ITIS				20 yrs
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٦.	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	1	ribute to th	e cause of death?
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0	Phys this aldii	2	1 Yes 2 No	Hospital: 1 inpatient 2	ER/Outpatien 28b. Time of			ome 5 Reside			)
0	fte ne	atlon	1/2 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		, ,		
Division	<u>a</u> # # # = =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At building, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. Location (Str City or Town		er or Rurai	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C		nysician: To the best of my kinner: On the basis of examinand manner stated.							
	To th withir To th compl	Me	29b. Signature and title of certifier	0 .1	7	29c. Licens			d. Date signed		
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	718			UGOOD MD	em 23a) (Type, 912 S	ETON D	13774 RIVE C	um BER	2LAND	MD	21502
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 200	32 Registrar's Sig	nature	Spark					

			1 - For State Registrar	State of Maryla	ind / Depa <i>Ce</i>	artment <i>rtificate</i>	of He	alth an eath	d Mental Hy	giene Reg. No		4 15	888
**	Physici /Medic		1. Decedent's Name (First, Middle, Last) DAVID	EE	MAYN	ARD			2. Date of De MAY 4,	Day	Yea 4		of Death
4.	Examir		4a. Facility Name (If not institution, give s 13185 ZEKIAH DRIVE	·		WA	LDOR				County of De	_ES	
	Funeral Director		5. Social Security Number 6. Security Number 235-64-6728 Usuel Residence of Decedent	M 2□F 63	s. last birthday) Yrs.			Under 24 Hours N	Ain. 8. Date of Bir (Month, Da DEC. 27	ay, Year)	40 WE	irthplace (Stat Country) ST VIRO	e or Foreign
	ne Marylan 8a-f show	Director	10a. State 10b. County  MARYLAND CHARLES		City, Town or Lo								City Limits es 2 \ No
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it a Medical Experiment Experimed	by Funeral	10e. Street and Number  13185 ZEKIAH DRIVE  11. Marital Status  1 Never Married 200 Married 3 Widowed 4 Divorced	II 185, CIVE	050_		0601 nt of Hispa y Cuban, I	anic Origin? Mexican, Pu Specify:	(Specify Yes or No ento Rican, etc.)	UNI	Black, Wh	ATES nerican Indian,	
Maryland 21215-0036	ad within 72 h giene. er than "natu i, it e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done duri		working	16b. Ki	nd of Busines	s/Industry	
ryland	thould be filed and Mental Hygi marked other matic event, I	To Be (	17. Father's Name (First, Middle, Last)  EARL MAYNARD  19a. Informant's Name/Relationship (Tyx)	oe Print)	19h Mailir	on Address /		JULIA	Name (First, Middle BARKER Rural Route Numbe			Tin Codel	
altimore, Ma	Pages 1 and 2 s nent of Health ar int: If item 27 is iry or other trau		PHYLLIS MAYNARD—W.  20a. Method of Disposition  1 A Burial 2 Cremation 3 Re	IFE 20b.	13185 Place of Dispo cemetery, cren	ZEKIA sition (Name matory or oth	H DR	., WAL	DORF, MD	2060 20c, Lo	)1 cation - City o	r Town, State	
Baltin	permit. Pages Department of Important: If i eny injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	M00053	22 H	AMILY Name and UNTT F	Address o	of Facility AL HOM				LE, WV	
).	Physician /Medical		23a. Par1. Enter the disease, or complic shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de e cause on each line.  Due to for as a conse	robie c	er the mode	of dying, s	Such as card	flac or respiratory as	ZU6(	<del>)4</del>	Approxim Interval B Onset an	etween
8/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	a Me equence of):	llitu	2						
O. Box 68	death certifi e attending i id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1   Live birth 2   Fe 4   Pregnant at time of 9   Unknown	tel déath 3 □	Ectopic preg				2	3d. Date of de	elivery Day	Year
1	w requires that the been signed by th should be detache		Part II. Other significant conditions conf	tributing to death but not re	sulting in the ur	nderlying cau	se given ir	n Part I.	23e. Did to			o the cause of	
al Kecords,	The law ate has b page 2 st	Completed									death?	utopsy finding completion of s 2 \( \text{No} \)	s available cause of
VItal	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			-		eath (Check only o				
Ion or	ding Phy	atlon: To	1 Yes 2 No '''  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		. Injury at Work?	4 □ Nursing 2 □ No	Home 5 Hesid 28d. Describe h			ecify)	
DIVISION	in Diffe	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec					28f. Location (S City or Tow	m, State)			mber,
	Hospital 24 hours a Funeral I	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exemination	ician: To the best of my kr er: On the basis of examin	iowledge, death ation and/or inv	occurred at restigation, in	the time, o	date and pla on, death oc	ce, and due to the c curred at the time, of	cause(s) a	and manner a: place, and due	s stated.	(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.			icense nu			29d. Date	signed (Mont	h, Day, Year)	
1.	21761		30. Name and address of person who con				"000	1151			Y 4, 20	JU4	
	Ď Ζ <sup>*</sup> . Sta	e.	R. TIMOTHY PACE, M 31. Date filed (Month, Day, Year)	32. Resistrar's Sign	aturo		#202	, WAL	DORF, MD	206	02		
	Registra		MAY 0 6 20	104 Sener	1. A	bert							

State of Maryland / Department of Health and Mental Hygiene 2 0 0 15887 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day May 2,2004 12:35P M Marguerite Louise Myers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F 80 Director 225-28-6681 Jan 22 1924 Brunswick, MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits MD Frederick Knoxville Director 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1428 Souder Road 21758 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after ☐Yes 2 XNo f Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural', Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 72 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Ia marked other than iry or other traumatic avant, the Me Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Eury Frances Ella Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo P. Myers, Husband 1428 Souder Road, Knoxville, MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department important: If any injury or \* 4 □ Donation 5 □ Other (Specify) Park Heights Cemetery 5/5/2004 Brunswick, MD 21. Signal in Turgual Service Licenson

Barbara A. Williams, Owner 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Obestruetive /Medical Due to (or as a consequence of) Examiner Conjustive Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury Due to (was a consequence of): Examiner certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy jo Month Day 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe þ neemmonia 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed peen Country arter disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 17 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Impatient 2 ER/Outpatient 3□ DOA this After thi funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. D0054636 May 2, 2004

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

Syed Haque, MD, 700 Montclaire Avenue, Frederick, MD 21701

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2004

31. Date filed (Month, Day, Year)

P.O. Box 68760 Division of Vital Records, within 24 hours efter death To the Funaral Director: completely filled in by the

Baltimore, Maryland 21215-0036

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060478 MAY & 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Afaq Ahmad M.D. 625 Kent Avenue Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

8 2004

			For	State of N	Maryland				nd Mental H	ygiene	9		
			1 - State Registrar			Cert	ificate of l	Death		Reg. No	200		5889
PI	nysicia	an	1. Decedent's Name (First, Middle	. Last)	Nic	-1			2. Date of I	Day			ime of Death
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E	xamin	er	SACRED HEAR	1 - 0			CUMBI				ALLEC		,
	neral ector		5. Social Security Number 2/8-60-0935		Age (In yrs. Ia		If Under 1 Year Months Days		Min. 8. Date of E (Month, I		9.	Birthplace (S Country)	State or Foreign
pug	522		Usual Residence of Decedent  10a. State 10b. County		10c, City	, Town or Loca	ation			- 1- 1-		10d. Ins	ide City Limits
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ath wit	unt b	Funeral Directo	25701 Shac	by LANE			2156				USA		
er de	T Section	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Marr	12. Was Deceder Armed Forces	s?.	S. 13. Wa	as Decedent of Hi Yes, specify Cuba	ispanic Origin In, Mexican, P	? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - A Black, W	merican Indi /hite, etc.	ian,
hours after	Exam	by	3 Widowed 4 Divorced	ied 1 □ Yes 2 ☐ If Yes, Give Year or Dates	S:	10	JYes 2XNo	Specify:			Specify: U	hite	
72 ho	nation, of tems to a cross stoward of editing at	Completed	15. Decedent (Specify only highes	's Education it grade completed)		16a. Decede (Give ki	nt's Usual Occupa nd of work done of NOT use retired	ation during most of	f working	16b. K	ind of Busine	ss/Industry	
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	omer men	Ø	17. Father's Name (First, Middle,	Last)		//	MARC		Name (First, Midd	le, Maiden			
Viar Menta	atic e	To B	Homer Be	AVERS				Hildr	+ MAY.	540	OK		
Mar 12 sho h and	Term I		19a. Informant's Name/Relations			19b. Mailing	2		or Rural Route Num			e, Zip Code)	. 1
Tanc Health	other 1		20a. Method of Disposition	son-Drug 4 +4		lace of Disposit	tion (Name of		Stern port	20c. L	ocation · City	or Town, St	ate
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Daitimo	any injury		21. Signature of Funeral Service	Licensee	1,00		Name and Addres		r. I		Long	CONING	
n & 5	E & 3		Jas. Meter	7	= 1.45	Eic	Khern-Me	1	Fernoin Ho	me P	4	ylund	
	*		23a Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	omplications that caus only one cause on each	i line.	. Do not enter	the mode of dyin	g, such as cai	rdiac or respiratory	arrest,		Interv	ximate al Between t and Death
Phys /Me	ician dical		disease or condition resulting in death)	a. Due to (or a	as a consequ	ence of):	~ 2/	vok	٤			3 h	veiks
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OX OB/	attending pn	0	IF FEMALE:	T									
g # g	for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	death 3□E	ctopic pregnancy Other (specify)				23d. Date of Month	delivery Day	Year
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e la v	nas 10 2	Completed							24a. Wa	is an lopsy rformed?	24b. Were prior death	to completio	dings available n of cause of
VITAI H	certificate na rector, page	e Co	25. Was case referred to medical					26 Place of	1 ☐ Yes	2 1 No		es 2 N	0
COU.		To B	examiner?	Hospital:	itient 2	ER/Outpatient	3 DOA Othe	0.00	ng Home 5 ☐ Re		6 □Other (S	ipecify)	
_ :	Atter this funeral di		27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of Ir (Month, L	njury Da <i>y Year)</i>	28b. Time of Injury	28c. Injun Work		28d. Describ	e how inju	y occurred		
UIVISION  I or Attending after death.	by the fi	ertification:	2 Accident investig	not be 290 Place of I	Injury - At ho	me farm stree	M 1 []	Yes 2 □ No	28f. Location	(Street an	d Number o	Rural Route	Number
o the	filled in by	ertif	4 Homicide determ	building,	etc. (Specify	()	st, ractory, cinco			own, State		112/1/00/0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVISIO  the Hospitel or Attending 24 hours after death	etely fille	edical C		g Physician: To the bes Examiner: On the basis and manner	of examinat								iuse(s)
To th	to the Fund completely f	Me	29b. Signature and title of certifie	r			29c. License				te signed (M		
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no	11		30. Name and address of person		_			0	mberland	I M.	rula.	11 2	1501.
// /	Sta	te.	31. Date filed (Month, Day, Year)	Pillai M. L.	o. 916 strar's Signat		in Drivi	e, Cur	MBEFIANC	110	ryia	, 01 2	1.00
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	/Medio Examir		4a. Facility Name (If not institution, gi		r)	4b. City,		ocation of Dea	May	40	. County of	0 4 Death	12:17A <sup>M</sup>
1	Exami	iei	Frederick Mem				eder				Fred		ck
	Funeral Director		5. Social Security Number 6.		Age (In yrs. last birthe	(ay) If Under		If Under 24 Hrs Hours Min		irth ay, Year,		. Birthpl	lace (State or Foreign try)
	2		Usual Residence of Decedent										
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	th the	irec	10e. Street and Number			10f. Zip	Code			10g. Ci	itizen of Wha	at Coun	try?
	ath w	ai	6229 Linganore I	Road			21701				ited S	tat	es
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ X Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1 X Yes 2 [ If Yes, Give Year or Dates	nt Ever in U.S. s? ] No ::1951-54	13. Was Deced If Yes, spec		panic Origin? (5 , Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Black, Specify:	America White, 6 Whi	etc.
21215-0036	72 hou nature dical E	Completed	15. Decedent's E (Specify only highest gi	Education	16a. D	ecedent's Usua Give kind of wo	al Occupati rk done du	ion ring most of wo	rking	16b. H	(ind of Busin	ness/Ind	lustry
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ylan	Menta be Menta be with the marked attic even	To B	Wilbur Jacob No	ottingham					Beech N				
Maryland	nd 2 sho lith and 27 is ma r trauma		19a. Informant's Name/Relationship Norma Nottinghan						ural Route Numb Frederi			1 <i>te, Zip</i>	_
ore,	of Hee of Hee if item	13	20a. Method of Disposition  1 ABurial 2 Cremation 3	Removal from Stat	20b. Place of D cemetery,	isposition (Nan crematory or o	ne of ther place)		Date	20c. L	ocation - Cit	y or To	wn, State
Baltimore,	it. Pag intment intent: injury c		*4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lice	ify)	Mt.	Olivet	d Addross		10/2004		ederic		MD
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Ω.	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in the	e underlying ca	ause given	in Part I.		tobacco (		te to the	e cause of death?
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					ath (Check only	one)			
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Division	or Attendi efter death. Director: A in by the fu	Certification;	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of I	njury - At home, farm etc. (Specify)	, street, factory	, office		28f. Location ( City or To	Street an wn, State	d Number o	r Rural	Route Number,
_	To the Hospitel or A within 24 hours efter To the Funerel Directorpletely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and manner:	st of my knowledge, of of examination and/ostated.	eath occurred a r investigation,	at the time, in my opin	, date and place tion, death occu	, and due to the irred at the time,	cause(s)	and manne d place, and	or as sta	ted. the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	^		1	. License n			29d. Da	te signed (N	fonth, D	ay, Year)
,			S Monon, M	.D .			1005	5793		5	1610	7	
	20+1		30. Name and address of person who	completed cause of	1 3 6'	pe, Print)	MD						
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12	Registr	ar	MAY	7· 2004	Sever	Ø	000	aks					

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Naylor Naylor May 2004 8:15 Margaret Η. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mount Airy
If Under 1 Year | If Under 24 Hrs. 710 Meadow Field Court Frederick 8. Date of Birth (Month, Day, Year) Oct. 17, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🛛 F Yrs 48 1955 Maryland Director 220-62-2127 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 21771 710 Meadow Field Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White ğ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be filment of Health and Mental H tant: If item 27 is marked oil jury or other traumatic even and Mental I Thomas Hughes Alice Burch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ricky C. Naylor / Husband 710 Meadow Field Court Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If ite
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once. 1 

Burial 2 □ Cremation 3 □ Removal from State May 5, 2004 St. Michael's Cemetery ' 4 ☐ Denation 5 ☐ Other (Specify) Mt. Airy, Maryland 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METHSTATIC BREAST CANCER Physician 3.5 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transit Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last sicien and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical β use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 2 × No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Anatural 2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funerel Director: Af death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō YSC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 501 W. SEVENTH ST. FREDERICK MD 21701

ignature

B Sports 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M, O'CONNOR MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - State Registrar	State of Mary		rtificate d			Reg. No. 200	
Physicia	an	Decedent's Name (First, Middle, Las					2. Date of De Month	Day Yea	
/Medic	cal	4a. Facility Name (If not institution, give	Duane	0gg	45 Cit. Town		April	29 200	
Examin	er	Montgomery Genera				n, or Location of De	eath	4c. County of Do	
Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Ye				gomery Birthplace (State or Foreigi Country)
Director		290-14-0569 Usual Residence of Decedent	XIM 2□F 79	Yrs.	Months Da	ys Hours M	in. (Month, Da April	26,1925	Ohio
thow		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
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jiene. rthen "neturel", or Items 23e or 28e-f show The Medical Examiner must be notified at	D.	10e. Street and Number	•		10f. Zip Cod			10g. Citizen of What	,
ns 23	Funeral	24340 Newbury Roa	12. Was Decedent Ever	in U.S. 13.	Was Decedent	20882 of Hispanic Origin?	(Specify Yes or No	United :	States mencan Indian.
or Re-	표	1 ☐ Never Married 2 A Married	Armed Forces? 1 ☐ Yes 2 🛣 No				(Specify Yes or No lerto Rican, etc.)	Black, W	
el, o	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:		Specify:	√hite
dical	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece (Give	dent's Usual Oc kind of work do	cupation one during most of t tired)	working	16b. Kind of Busines	ss/Industry
then then	m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.				D .11.	0 1
Hygen the		17. Father's Name (First, Middle, Last)			Sales	1	lame (First, Middle	Building , Maiden Sumame)	Supply
Mental arkad c atic eve	To Be	George Wilson Ogg					Kraus	,	
and M Is mar eumat		19a. Informant's Name/Relationship (T	урө, Print)	19b. Maili	ng Address (Str			er, City or Town, State	, Zip Code)
f Health and Meritem 27 is marke other treumatic		Clara E. Ogg/ Wife	2	24340	) Newbur	y Road,	Gaithersb	urg, Maryl	and 20882
of tof He		20a. Method of Disposition  1 Burial 2 XCremation 3 D		Ob. Place of Dispo	osition (Name of matory or other	place	Date	20c. Location - City	
ent		'4 □Donation 5 □ Other (Specify		Metropol	itan Cr	ematoriun	/2004 Inc.	Alexandria	a,Virginia
Department Importent: any injury c		21. Signature of Funeral Service Licens	500	/ 03	Name and Ad	dress of Facility 101eswort	h P. A.,	Funeral Ho	ome
		Sode of	arpen	20	5401 Ric	dge Road,	Damascus	, Maryland	1 20872
ysician Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Cardia	ie Nors	1	dying, such as card	lac or respiratory a	rrest,	Approximate Interval Between Onset and Death
kaminer		1	Due to (or as a con		1001	key dis	see 6		10 VCALK
	er	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a eq	neequaneo or):	120 0	14 mis			( VEOU)
ansit	Examiner	Cause (Disease or injury that initiated events	· Pratito	ce Mel	le tes				
sician and burial-transit	Ex	resulting in death) Last	Due to (or as a cor	nsequence of):					
چ و ا	licai		d						
attending ph	/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy				22d Data of a	
ned by the atten detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregna Other (specify			23d. Date of d Month	Day Year
500	by	Part II. Dther significant conditions co	entributing to death but no	t resulting in the u	nderlying cause	given in Part I.			to the cause of death?  Probably 4 □Unknown
been sig	etec						-		
has 90 2	Completed						24a. Was autop perfo	prior to death	autopsy findings available o completion of cause of ? es 2 \square No
is certificate director, pag	Be (	25. Was case referred to medical examiner?					eath Check onl o		
v/ :=	ို	1 ☐ Yes 2 ☑ No	**	2 ER/Outpatier	nt 3□ DOA	Other: 4 Nursing		dence 6 Other (Sp	pecify)
r death. ector; After thi by the funeral of	ion;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	\	njury at Work?	28d. Describe I	how injury occurred	
ctor:	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm str		Yes 2 No	28f Location /	Street and Number or i	Rural Route Number
Dire d in b	ertii	4 Homicide determined	building, etc. (S)	pecify)	oot, factory, offi	vo.	City or Tov	vn, State)	Tarar Nobie Namber,
within 24 hours after upart To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exem	vaicien: To the best of my iner: On the basis of examend manner stated.	knowledge, death	n occurred at the vestigation, in m	e time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and di	as stated, ue to the cause(s)
within Fo the	Me	29b. Signature and title of certifier				ense number		29d. Date signed (Mor	nth, Day, Year)
		I flot / yr	cum-		D 9	33067		April 29	2004
		30 Name and address of pers who c	ompleted cause of death	(Item 23a) (Type,	Print)	21	1 7 2 4 5	•	
	- 1	Robert Gallino MD	18109 prm	ice phillip	· Pr	oluch L	1d 208	32	

		ricase i	State of Maryland / [				
		1 - For State Registrar	Olate of Maryland / L	Certificate of		Reg. No.	15893
*		Decedent's Name (First, Middle, Last)			2. Date of	Death	3. Time of Death
Phys /Mo	ician dical	John	Matthew	Peas	e Mey	6, 2004	1126 A M
	niner	4a. Facility Name (If not institution, give :		4b. City, Town, or	Location of Death	4c. County of Death	
		University of May	land Nudical Co	uto Buinn	rope		
Funer		5. Social Security Number 6. Second	7. Age (In yrs. last bir	thday) If Under 1 Year Yrs. Months Days	Hours Min (Month	Birth 9. Birth Cou	plece (State or Foreign intry)
Directo	or	220-86-8954 Usual Residence of Decedent	39	113.	JAN.	13, 1965 MAR	YLAND
yland		10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
e Mar	ctor	MD QUEEN AN	NE'S STEV	ENSVILLE			1 ☐ Yes 2X No
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Experience and the natities and the majority of the statement of the statemen	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
s 23a	Funerai	106 KENT POINT RO	12. Was Decedent Ever in U.S.	21666	0.110.00	USA	
ter de	Į.	11. Marital Status  1 X Never Married 2  Married	Armed Forces?  1  Yes 2  No	If Yes, specify Cuba	ispanic Origin? (Specify Yes or In, Mexican, Puerto Rican, etc.)	No- 14. Race - Ameri Black, White	can indian, , etc.
036 urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2XX No	Specify:	Specify:	THITE .
5-0 72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a.	. Decedent's Usual Occupa (Give kind of work done of	ation	16b. Kind of Business/Ir	ndustry
	JQ II	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	))	RESTAURANT/	
tygier tr		12 17. Father's Name (First, Middle, Last)	1 G	ENERAL MANAG		ENTERTAINME	NT
and the final hold of	Be	ARTHUR LEONE PEASE	TR		18. Mother's Name (First, Mid MARJORIE ANN		
Maryland 21215-0036 42 should be filed within 72 hours at th and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Mouldal Exam	ဥ	19a. Informant's Name/Relationship (Ty)		. Mailing Address (Street a	and Number or Rural Route Nu		Code)
Malth all 27 18		MARJORIE ANN PEASE			NTE DR., CHEST		
of He rother		20a. Method of Disposition	comoto	Disposition (Name of ry, crematory or other place	Date	20c. Location - City or To	own, State
Page Page ment ant: if		1  Burial 2  Cremation 3  R  '4  Donation 5  Other (Specify)	emoval from State		ERY 05/13/2004	STEVENSVILLE	E, MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinian manual confiled at	SUC SUC	21. Signature of Funeral Service License	A The	FELLOWS, HEI	ss of Facility LFENBEIN & NEWN CK ROAD, CHESTE	IAM FUNERAL HO	ME, P.A.
\$ 1		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. Do r				Approximate Interval Between
Pnysicia	n	Immediate Cause (Final disease or condition	Massine Le	7 2	(c)		Onset and Death
/Medica		resulting in death)	Due to (or as a consequence	of):	thorax		
Examine		Sequentially list conditions, b	Blunt Lun	5 Injury			
led sit	nine	if any leading to minectate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequences	an: 5 /			
xecul and and	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of	of):			
3760, ate be executed sysicien and he burial-transit	cai						
Box 68 leath certificate attending phy			30.7		1 1 1	200	110
I <b>Records, P.O. Box 68</b> The law requires that the death certifica to have been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death	3 ⊟Ectopic pregnancy	Now You	L Out Out of autive	LUL -
O. E he dea the att	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)	GERTIFICATION APPROV	ED BY MEDICAL MOMPHE	Day Year
15, P.O. Ires that the de signed by the a	Phy	9 □Unknown  Part II. Other significant conditions con	tributing to don't but not consisting is	the condent in a second	and David		to a super of develop
Records, he law requires the has been signed ge 2 should be company.	d by	Hemoper tone		i trie driderlying cause give		id tobacco use contribute to t □ Yes 2 🙀 No 3 🗆 Prob	_
COrd  * requir  been si should l	Completed	-112110 per 1 voruc					
The tav	E D						psy findings available mpletion of cause of
	ပိ	25. Was case referred to medical			1 ☐ Yes	s 2. SNo 1 ☐ Yes	2 No
	0 8	examiner?	ospital: 1 ☑ Inpatient 2 ☐ ER/Out	tratient 30 DOA Othe	26. Place of Death (Check on	y one) esidence 6 □Other (Specifi	
g Physicar this ieral dii	F.	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Injury		e how injury occurred	7)
ISION ( Itending F death. ctor: After y the funer	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	5-6-04 10		es 2 No Subje	elis with	SUV
DIVISION Of VIta after death.  I or Attending Physician: after death.  Director: After this certific in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location City or	(Street and Number or Rura	I Route Number,
Urs aff			Roadway		2001	aster Rd, Sta	ensuille, Mi)
Hospital 24 hours a Funerel I	Medical	29a. Certifier (Check only one)  12 Certifying Phys 2 Medicel Exemin	icien: To the best of my knowledge er: On the basis of examination and	, death occurred at the tim d/or investigation, in my op	e, date and place, and due to the inion, death occurred at the time.	ne cause(s) and manner as st	ated
DIVI To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Med	29b. Signature and title of certifier	and manner stated.	29c. License	number	29d. Date signed (Month,	Day, Year)
⊢≯⊢ŏ		N.		57	11.54	5/1/ low	
		30. Name and address of person who con	mpleted cause of death (Item 23a) (	Type, Print)	2107	3/6/09	
10 KIL		Thomas Scalen	MO. 22 Sou	the Green S	51654 t. Baltimus,	MD 2120	1
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1.6.	/		
Regis	strar	mAY I 3 Z	JU4 Killadine At	A TOTAL S			1

	1 - For State Registrar  1. Decedent's Name (First, Middle, La:	State of Marylan		rtment of H tificate of L			g. No. 20(	3. Time of Death
Physician /Medical Examiner		EASKORN  street and number)		4b. City, Town, or CUMBER		Month APAL	Day Ye 23 200 4c. County of D	eath 10 <sup>25</sup> A
Funeral Director	5. Social Security Number 6. S 214–12–3493	ex 7. Age (In yrs. XD M 2□ F 81	last birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 H. Hours Mi		9. 1922 WE	Birthplace (State or Forei Country) ST VIRGINIA
with the Maryland a or 28a-f ehow by routilist at	10a. State 10b. County		ly, Town or Loc			11	0g. Citizen of What	10d. Inside City Limit  X∃XYes 2 □ N  Country?
72 hours after death with the Maryland "natural", or Items 23e or 28e-f ehow edical Exarta or must be rediffed at leted by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2 XNo If Yes, Give Year or Dates:	If	21502  Vas Decedent of Hi Yes, specify Cuba  □ Yes 2월 No	spanic Origin?	(Specify Yes or No- orto Rican, etc.)		vmerican Indian, White, etc.
within iene.	15. Decedent's Ec (Specify only highest gra	ucation	(Give k	ent's Usual Occupa ind of work done of O NOT use retired NCIPAL	turing most of w	rorking	EDUCAT	
be fill Hall Hall Hall Hall Hall Hall Hall H	17. Father's Name (First, Middle, Last)	EASKORN	10h Mailine	Address (Street	ELLA	BELLE E	EDENHART	
t and 2 Health a em 27 li	THOMAS PREASKORN  20a. Method of Disposition	/ SON 20b. P	ROUTE	1, BOX 1	22-A-40	Rural Route Number,  KEYSER,  Date		25- 26726
permit. Pages Department of I Important: If Its any injury or o once.	1 ØBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif)  21. Signature of Funeral Service Licen	E.	OAK GRO	OVÉ CEMET	ERY 04/	27/2004 :	MORGAN'I'OV	VN, WV
Physician /Medical Examiner	23a. Pan1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. A C C H C in Due to (or as a consequence)  Due to (or as a consequence)	h. Do not ente  (CR)  uence of):	the mode of dying	E STREE g, such as cardi	T, CUMBER	LAND, MD	Approximate Intervat Between Onset and Death
antificate be executed ing physicien and eas the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	c						
that the death certifics ed by the attending pt detached for use as it	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3 □	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
igne bed by	Part II. Other significant conditions of		-	, ,				o to the cause of death?  Probably 4 Unknow
The page	HYPERTENSIO	<i>ا</i>				24a. Was an autopsy perform	ed? prior to death	autopsy findings available completion of cause of ? es 2 No
T P	25 Was case referred to medical examiner?  1  Yes 2 No  27. Manner of D ath  1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3□ DOA Otha 28c. Injury Work	at Nursing	eath (Check only one Home 5 Resider 28d. Describe how	nce 6 Other (S	pecify)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely littled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stree	M 1 🗆 Y	es 2 □No	28f. Location (Str. City or Town,		Rural Route Number,
he Hospita In 24 hours he Funeral pletely lillec edical C	29a. Certifier (Check only one)  1 Certifying Ph. 2 Medical Exam	rsician: To the best of my knowiner: On the basis of examinat and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occ	ce, and due to the cal curred at the time, da	use(s) and manner te and place, and d	as stated. lue to the cause(s)
To the within O To the comp	29b. Signature and title of certifier	C. Jenk	220) 75	29c. License			d. Date signed (Mo	
State Registrar	30. Name d address of person of the desired of the desired desired (Month, Day, Year)	32. Registrar's Signal	112 5	In Da	ve, le	neboulan	& MD.	21502

			1 - For State Registrar		epartment of Health and Certificate of Death		ene 2001	15899
	Dharain'		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medi		VIRGINIA	PRICE			28 2004	10:20 A. M
	Examir	er	4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Deat	h	4c. County of Death	
			MARINER HEALTH ( 5. Social Security Number 6. Sex	OF FOREST HILL  7, Age (In yrs. last birthd	FOREST HILL  fav) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	HARFOR	
	Funeral Director		212-38-5155	M 2 1 92 Yr	Months Days Hours Min	Jan. 3	1912 M	nplace (State or Foreign untry) aryland
	D.		Usual Residence of Decedent			juni. 0,	1712	ar y larra
	arylar ehow	-	10a. State 10b. County	10c. City, Town o				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f ehow event, the Medical Exaciliar mant ke notified at	Director	Maryland Alle	gany	Cumberland, I		600	1 X Yes 2 No
				oter Place	10f. Zip Code 21502	log	. Citizen of What Cou	USA
		Funeral			13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No-	14. Race - Amer	ncan Indian,
9	or Ite	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, White	
9 9	ural',	d b	3 Widowed 4 □ Divorced	Year or Dates:			Specify:	White
ပု	n 72 in 72 in at	lete	15. Decedent's Educa (Specify only highest grade	completed) (C	ecedent's Usual Occupation Give kind of work done during most of wor fe. DO NOT use retired)	rking 161	b. Kind of Business/li	ndustry
Maryland 21215-0036	with jene. r ther	To Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	2	Owr	n Home
	e filed al Hygid I other vent, II		17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Mai		
	should be and Mental marked c			ry C. DeMoss			7. (Christm	/
Mar	h a 7 is		19a. Informant's Name/Relationship (Type Nancy A. Reynole	ds/Daughter 196. N	lailing Address <i>(Street and Number or Ru</i> P. O. Box 69			
ē,	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b. Place of Di	sposition (Name of		Location - City or T	
Ë	0 0 = =		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 1 ☐ Donation 5 ☐ Other (Specify)	noval from State	est Memorial Park	5/3/04	Cumberl	
Baltimore,	permit. Pag Department Important: I eny injury c		21. Signature of Funda 1 2 rvice Licensee	Q/A	22. Name and Address of Facility	Kight F	uneral Ho	
n —	89 E 2 9		William	MINTE	309-311 Decat			
	**		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused he death. Do not cause on each line.	D	4		Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Atheroscle	whie Caroliov	os cular	disense	Onset and Death
	/Medical Examiner		1650mily wi dealth)	Due to (or as a consequence of):				
	\$5 miles	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
Ď,	e exec ien an ırial-tr	Exa	resulting in death) Last Due to (or as a consequence of):					
2/PU	the death certificate be executed y the attending physicien and ched for use as the burial-transit	dlcal	d.					
ox o	leath certific attending p	/Me	IF FEMALE:	. If yes, outcome of pregnancy				
o n	atten for u	cian	in the past 12 months?	1☐Live birth 2☐Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	ery Day Year
j.		Physician/Me	1 ☐ Yes 2 💆 No 9 ☐ Unknown	oli otilai (specity)				
ιν, Τ	requires that the sen signed by I tould be detact	by P	Part II. Other significant conditions contri	,	4	23e. Did tobacc	co use contribute to t	he cause of death?
cords,	v require been sig should b	led t	Moderte	to Severe	Austre Stenosu	1 ☐ Yes	2 No 3 □ Prot	bably 4 □Unknown
Ū		Completed				24a. Was an autopsy	24b. Were auto	opsy findings available
r =	The cate ha	Con				performed	? death?	ompletion of cause of
NI S	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	pital:	0.1	th (Check only one)		
5	Phys rat dir	. To	1 165 202 140	1 Inpatient 2 ER/Outpa		ome 5 Residence		y)
0	ding th. Afte	tlo-	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how in	ijury occurred	
UNISION	Atter or dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rura	al Route Number,
5	s afte	Certification:	4 Homicide building, etc. (Specify)					
	Funer Funer Tely fills	Medical (	29a. Certifier  (Check only only only only only only only only					
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funeral Director, Attent his certific completely filled in by the funeral director,		one)  29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month,	
	10		) All	Y MD	D 005660	7 A	mil 29 1	2004
,	10		30. Name and address of person who comp	pleted cause of death (Item 23a) (Tvr	pe, Print)		~ /	,
	1125		JOSEPH ANG	ELO #106	pe, Print) 602. S. Atwood	Rd. BEZA	IN MD	21014
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	lon de			
	Registra	ar	APR 3 © 2004	from B	boartel			

		1_ For State	State of Maryland / Department		Mental Hygien			
Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Last)  Daniel Pettig  4a. Facility Name (If not institution, give si  4206 Garnet Dr	rew treet and number)	4b. City, Town, or Location of Dea	2. Date of Death Month D Apr • 21	year 3. Time of Death 2004 6:50 A M		
Funera Directo	_	Social Security Number 6. Sex	• M 2 F 7. Age (In yrs. last birthday) Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 20, 1931 MAS				
(1215-0036 within 72 hours after deeth with the Maryland ene. than "naturat, or items 23e or 28e-f show the Madical Exeminer must be notified at	Director	10a. State 10b. County  MD Freder  10e. Street and Number	ick	Middletown  10f. Zip Code	100 0	10d. Inside City Limits 1 ☐ Yes 3€ No		
leeth with ns 23a or must be r	erai Dir	4206 Garnet Dr.		21769		USA  14. Race - American Indian,		
JUSO lours after of ural', or iten LEverniner	d by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced    Never Married 2 Married 1		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:		Black, White, etc.  Specify: White		
Maryland 21215-0036 nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 Is marked other than "natural", or rtraumatic event, the Madical Exert	Completed	(Specify only highest grade completed) (Giv  Elementary/Secondary (0-12) College (1-4or 5+)		edent's Usual Occupation a kind of work done during most of working DO NOT use retired)  CDR		16b. Kind of Business/Industry  USNAVY		
IOTE, Maryland 21215-UU36 ges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mental Hygiene. It is Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinat must be notified at	To Be C	17. Father's Name (First, Middle, Last)  Charles Sumner Pettigrew  18. Mother's Name (First, Middle, Maiden Sumame)  Etta G. Butler						
3, Mar and 2 sh lealth and m 27 is m her traum		19a. Informant's Name/Relationship (Type Grace Pettigrew	(Wife) 4206	ong Address (Street and Number or Richard Dr., 1	Middletown	n, MD 21769		
DallIMOre, permit. Pages 1 ar Department of Hea Important: If Item any injury or other pnce.		20a. Method of Disposition  1	Arlingt	con National 5. Name and Address of Faculty Onald B. Thom	/17/04 Ar] pson Funer	Lington, VA		
anth certificate be executed  Attending physician and for use as the burial-transit	al Examiner	23. Part1. En er the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line.    Approximate Interval Between Onset and Death Section of the Conditions of the Con						
The law requires that the death certificate the has been signed by the attending phystage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy  1 Live birth 2 Fetel death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown			23d. Date of delivery Month Day Year		
wrequires that the de been signed by the s		Part II. Other significant conditions controlled Ischemic Cardia	omycpathy	1		tobacco use contribute to the cause of death? I Yes 2 🗆 No 3 🗆 Probably 4 💆 Unknown		
vital neco	Completed by	Cirrhosis of the Peripheral vascul	lèver selonderry to an discuse	o chronic hepatitis	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No		
Attending Physical displays the funeral displays th	Certification: To Be	25. Was case referred to medical examiner?  1   Yes   2   No	spital: 1 Inpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Place of Injury - At home, farm, streething of the Stree	ott 3 DOA Other: 4 Nursing H 28c. Injury at Work? M 1 Yes 2 No	ath (Check only one)  lome 5 PAesidence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospitel or A within 24 hours after To the Funeral Direct Completely filled in by	edical Co	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
To the within to the comp	Me	29b. Signature and title of certifier	lein			ate signed (Month, Day, Year)		
10+1			Her mb po Be	Print) Dx 20 MIDDLE	N , www or	UD. 21769		
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	& Some				

			1 For State Registrar	State of Ma	aryland		artmen rtificat			and M		Reg. No. 2	004	1589
ı	Physic	ian	Decedent's Name (First, Middle CLAYTON	e, Last) FLETCHE	R	1	RADCL:	TEFE			2. Date of D Month MAY	eath Day	2004	3. Time of Death  3:45 P <sup>M</sup>
	/Medi Examir		4a. Facility Name (If not institution						Location of		PIAI		ZUU4	3:43 P
	LAGITIII		HEARTLAND HOU	SE, INC.			GRA	SONV	ILLE			QUE	EN ANN	Œ
	Funeral		5. Social Security Number	10X 14 00 00		ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	28,1922	9. Birthp	lace (State or Foreign
10 mg	Director		220-01-7781 Usual Residence of Decedent	8	1	Yrs.					JUNE	28,1922	MARY	LAND
	rland		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Man a-f sh	to	MD QUE	EN ANNE	G	RASON	/ILLE							1 ☐ Yes 2 🛣 No
	ath with the Marylan 23a or 28a-f show	al Director	10e. Street and Number 219 PERRY S C	ORNER ROAD			10f. Zip	Code 21638	3			10g. Citizen of USA		try?
21215-0036	after des	d by Funerai	11. Marital Status 1 □ Never Married 2 A Mar 3 □ Widowed 4 □ Divorced	If Yes Give	No		Was Decedif Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spo i, Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra Bla Speci	ce - Americ ack, White, of	etc.
15-(	c * 3	Completed	(Specify only highe	t's Education st grade completed)		(Give	dent's Usua kind of wor DO NOT us	rk done di	uring most	t of work	ing	16b. Kind of 8	Business/Inc	dustry
212	d within giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)		PENTE					CONST	TRUCTI	ON
and	buid be tiled Mental Hygi arked other atic event, il	o Be C	17. Father's Name (First, Middle, RUFUS EDMOND R	50.7							e (First, Middle	LEWIS	me)	
Maryland	12 sh h and h and 7 is m traum		19a. Informant's Name/Relations JEAN S. RADCLI									oer, City or Town		
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition  1 XX Burial 2 Cremation  4 Donation 5 Other (S	3 ☐Removal from State	Ce	ace of Disponentery, crer	sition (Nan	ne of ther place	)	C	Date	20c. Location	- City or To	wn, State
Balti	permit. Page Department Important: If any injury o		21. Signature ov uneral Service	Licenson D.		F		S, HEI	FENB	ÉIN		AM FUNER		ME, P.A.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. CAN  Due to (or as	CER O a conseque CER O	F LUNG ence of): F BLAI	er the mod	e of dying	, such as	cardiac c	or respiratory a	irrest,		Approximate Interval Between Onset and Death
O. Box 68760,	nt the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnan	ncy death 3	Ectopic pro						ate of deliver	ry Day Year
rds, P.O.	res tha igned be de	Ď	Part II. Other significant condition	ons contributing to death bi	ut not resul	lting in the ur	nderlying ca	ause giver	n in Part I.			tobacco use con	Α.	e cause of death?
Il Records,	The ate ha	Completed									24a. Was auto perfo 1 \( \text{Yes}	psy ormed?		sy findings available apletion of cause of 2 No
f Vita	Physician: 1 rthis certificat ral director, p	To Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:	int 2□E	R/Outpatien	t 3 🗆 DO	Other		1-3.5	ne 5□Resi	dence 6 X		D LIVING
Division of Vital	Attending Phirideath.		27. Manner of Death  1 ANatural 5 Pendir 2 Accident investi	gation	Year)	28b. Time of Injury	21 M	Bc. Injury Work? 1 ☐ Y	at ? es 2 □ N		28d. Describe	how injury occur	red	
Divis	safter de safter de ni Directo	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At hon c. (Specify)	ne, farm, stro	eet, factory	, office		1	28f. Location ( City or To	Street and Numb wn, State)	ber or Rural	Route Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the tuner	Medical (	29a. Certifier 1 Certifyir (Check only one) 2 Medical	g Physicien: To the best of Examiner: On the basis of and manner sta	of my know examination ited.	rledge, death on and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and made and place,	anner as sta and due to	ited. the cause(s)
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10	KK		204 medica	who completed cause of di	Rd	23a) (Type.	Print)	1,116	5 /V	u d	2/6	38		
	Sta Registi	4.5	31. Date liled (Month, Day, Year)  MAY 1	0 200 See 32. Recorder	ers Signatu	# 1	parte	و						

# Rickard, William Howiard Baltimore, Maryland 21215-0036

Please Type or Print in Black I	ndelible Ink. Ensure All	Copies Are Legible.	
State of Maryland / Dep	partment of Health and M	ental Hygiene 2 1 1 1	15898
te gistrar Cé	ertificate of Death	Reg. No.	10000
dent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
liam Howard Rickard		april 27 2004	15/5 M
lity Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	

		. For	State of Ma	aryland / D	epartment of I	Health and Mei	ntal Hygie	ne 2 nnl.	15898
		1 - State Registrar			Certificate of	Death	Reg.		19090
V		1. Decedent's Name (First, Middle,	Last)			2.	Date of Death		3. Time of Death
Physici /Medio		William Howard				0	yoril 2	7 2004	15/5 M
Examin	er	4a. Facility Name (If not institution,			4b. City, Town,	or Location of Death	v	4c. County of Death	
		Washington Coun			Hagers	1444		Washingt	ton County
Funeral			5. Sex. 7. Ag	e (In yrs. last birti 89	hday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye	ar) 9. Birth	place (State or Foreign
Director		212-14-7388 Usual Residence of Decedent		0,5		re	bruary	14,1915 C	onnecticut
land ow		10a. State 10b. County		10c. City, Town	or Location			1	10d. Inside City Limits
Mary -1 sh	į	Florida Duval		.Τa	cksonville				1X Yes 2 □ No
28a	Funeral Director	10e. Street and Number		<u> </u>	10f. Zip Code		10g.	Citizen of What Cour	ntry?
3s of	Ī	10875 Old St.Aug	mustino Dd			20055			,
Jeath Jeath	era	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Decedent of I	32257 Hispanic Origin? (Specify	/ Yes or No-	14. Race - Americ	can Indian.
r Iter	Fun	1 ☐ Never Married 2 ☐ Marrie	Apped Forces?		If Yes, specify Cub	an, Mexican, Puerto Ric	an, etc.)	Black, White,	etc.
urs a	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1967	1 ☐ Yes 2 No	Specify:		Specify: Whit	æ
filed within 72 hours after death with the Maryland Hyglene. yther than "natural", or Items 23a or 28a-f show ant, the Mudical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education	16a.	Decedent's Usual Occup	pation during most of working	16b	. Kind of Business/In	dustry
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od wi	So.		2		US Navy			Master Ch	ef
at H oth	Be	17. Father's Name (First, Middle, La	,		_	18. Mother's Name (F		len Sumame)	
Meni Meni arke	2	Frederick N. Ric	kard			Minna E.	Miinch		
and and is m		19a. Informant's Name/Relationship	э (Туре, Print)	19b.	Mailing Address (Street	and Number or Rural Re	oute Number, Cit	y or Town, State, Zip	(Code)
and ealth n 27		Donna_Shoop/Neio	:e		518 Pangbor	n Blvd. Hag	erstown.	Maryland	21742
of Hi of Hi fiter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	t □Removal from State	Complety	, CIGITIALUTY OF OLITOR DIA	Ca)	20c.	Location - City or To	wn, State
Pag ment ent:		4 Donation 5 Other (Spe		Rest I	Haven Cemet	ery May 1,	2004 I	Magerstown	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or Items 23a or 28a-1 show any figury or other treumatic event, the Madical Examinatment be notified at once.		21. Signature of Funeral Service Lie	censee	1. 0	22. Name and Addre	ess of Facility Doug	las A. F	iery Fune	ral Home
20E = 9		1 Janu	1 0 Tan	14	1331 Fast	ern Blvd. N	. Hagers	town Mar	vland 21743
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused by one cause on each lin	the death. Do no	ot enter the mode of dyi	ng, such as cardiac or re	spiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			enote co	adia on all	In de	2100	Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence o	i):	aiway	an in		11/25
Examiner		Consideration that a confidence	Chr	mi o	Estrutere	aiway	disco	26	54eas.
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icate be executed physician and s the burial-transit	edicai		d						
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eath certifi attending for use as	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 Ectopic pregnancy	v.		23d. Date of delive	iry
the att	sicia	in the past 12 months? 1  Yes 2 No	4☐Pregnant at 9☐Unknown		5 Other (specify)	,		Month	Day Year
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igned be det	by	Part II. Other significant condition	s contributing to death bu	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
yeiclen: The law requires that the death centi is certificate has been signed by the atlending director, page 2 should be detached for use a							1 XYes	2 No 3 Prob	ably 4 Unknown
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yeici is cer direc	OB	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatie	nt 2 ER/Out	patient 3 DOA Oth	er		6 □Other (Specify	()

To the Hospitel or Attending Phye within 24 hours after death.

To the Funerel Director: After this a completely filled in by the funeral directors. Medical Certification:

Division of Vital Records, P.O. Box 68760,

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Statural
2 Accident
3 Suicide
4 Homicide 5 Pending investigation 6 Could not be determined 29a. Certifier (Check only one)

27. Manner of Death

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D28365 29d. Date signed (Month, Day, Year) 4-29-04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

death (Item 23a) (Type, Print)

368 mil Streel- Horgesterm 19 02/740 AWZ4 HAPI 31. Date filed (Month, Day, Year)
MAY 0 3 2004

State Registrar

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 2004 15899 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician 0436 A M KATHARINE L. REID April 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 92 1 □ M 2 🗘 □ F WEST VIRGINIA 234-46-8148 Yrs. **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No WILLIAMSPORT Director MD WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 USA 16018 CLOVERTON LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 為☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: WHITE ð 3 Nidowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) DEPARTMENT STORE Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. DEPARTMENT HEAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) d 2 should be fi h and Mental F. Is marked ott Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked of any injury or other traument JENNIE E. FULTON DAVID S. BROWN P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16028 CLOVERTON LANE, WILLIAMSPORT, MD 21795 BETTY JANE DELLINGER/NIECE Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State MAY cemetery, crematory or other place) CHARLES TOWN, WV 1 Burial 2 ☐ Cremation 3 ☐ Removal from State EDGE HILL CEMETERY 3, 2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BROWN FUNERAL FROME, P.O. BOX 821, 327 W. KING ST., Charles m MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ncreatic arcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence of death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ crolo Carcinoma 1 Yes 2 No 3 Probably 4 Unknown Completed pertensión 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 1 No 1 Tyes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 🗌 Yes 1 Id Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No or Attand after death Director: 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funaral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapping stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30 MD0052136 (Item 23a) (Type, Print) Will consport pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 15900 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 30 2004 **Physician** Lewis Arthur Ridenour 0219 Αм /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Clearview Nursing Home Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 🔀 M 2 🗆 F 220-30-9394 August 28,1934 Maryland Director 69 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Show rel', or itema 23a or 28a-f shov Examiner must be notified at 1x Yes 2 □ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 East Potomac Street 21795 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. e filed within 72 hours after dal Hygiene.
I Hygiene.
other then "naturel; or iten 1X Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Leather Processing 8 Laborer nd 2 should be filed lith and Mental Hygi 27 is marked other r traumatic event, ii 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert E. Ridenour Thelma Irene Socks 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health iftem 27 if Jodie L. Burchett (Niece) 11320 Sword Road Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory April 30,2004 Smithsburg, Maryland permit. Page Department of Important: If any injury or once. \* 4 Donation Signature of Funeral Service Licer Osborne Funeral Home P.A. 425 South Conococheague Street Williamsport, Maryland 21795 Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 300 Algheimen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 4 □ Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Partinain Duncan 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? 1 Tes 2 46 Be

death certificate be executed Division of Vital Records, P.O. Box 68760, certificate director, this After Hospitel or Attending s after dea. To the Funerel Dir

2

Certification:

Medical

the Maryland

death

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Seaffifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number Tente ms APRIL 30, 2004 D (8019

21240

MD

State

To the

340 MILLST MAGERSTOWN VASAVT DATTE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Refistrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Maudella Richards 02 May 2004 3:15 p. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frostburg Allegany 187 South Water Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Days Hours 1□ M 2□**X** Yrs. 214-12-3403 90 May 28, Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s + ehov any injury or other traumatic event, Its Medical Exam as must be notified at 1 Yes 2 No Frostburg MD Allegany Funeral Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 187 South Water Street 21532 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married White 1 Yes 2 No Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Ř Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Ann Yates David J. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 187 South Water Street, Frostburg, MD 21532 Thomas J. Richards, Jr., Son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 05/03/2004 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility **Durst Funeral Home** ohn 57 Frost Avenue, Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) 10 months **Physician** RetroPeritoneal Sarcoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. as IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Hypertension, Old Age, Cardiomegly, Osteoporosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 **∠**No 1 Tyes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 █**X**lo Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 14464 May 3, 2004 dhin TISS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) : GP S. L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 3 2004 Registrar

		1 - For State Registrar AMEND IIEM #5	State of Maryla per fh g831 5/18						giene Neg. No. 20	04	1590
Physic /Med		Decedent's Name (First, Middle, Last,     Izak Jacob						2. Date of Dea Month April		rear	3. Time of Death $3{\rm li}10^{-}$ A $^{-}$ M
Exam Funera	iner I	4a. Facility Name (If not institution, give  Johns Hopkins Hos  5. Social Security Number 6. Security Number 16	spital	i. last birthday) Yrs.	If Under Months	Balt 1 Year   H	cation of Death  imore f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Yeer)	alti 9. Birthpl: Count	ace (State or Foreign ry)
Directo	r	Usual Residence of Decedent  10a, State 10b, County		city. Town or Lo	3 cation	8		Jan. 13	, 2004		yland  Od. Inside City Limits
the Maryla 28a-f sho	Director	MD Garı				Loch	Lynn		10g. Citizen of Wh		1 🛣 Yes 2 🗆 No
ING 21213-UU36  be filed within 72 hours after death with the Maryland tial Hygiene.  d other than "natural", or flems 23a or 28a-f show event, the Madical Exemples mant be notified at	Funeral	414 Maple Avenue  11. Marital Status  1 🖾 Never Married 2 🗆 Married	12. Was Decedent Ever in Armed Forces?  1 Yes 2 2 No If Yes, Give			21 ent of Hispa rfy Cuban, i	.550 anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		USA - America White, e	A In Indian, Itc.
10 21215-0036  I filed within 72 hours af al Hygiene. I other than "natural", or vent, the Wedleal Exem	Completed by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)		(Give	DO NOT us	k done duri	ing most of work	ing	16b. Kind of Busi		
Maryland 2  nd 2 should be filed  lith and Mental Hygi 27 Is marked other rtraumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Jacob Willia	am Rod <b>e</b>	heaver		18	3. Mother's Nam Wendi	e (First, Middle, Da:	Maiden Sumame) L1		kman
		Jacob W. Rodeheave 20a. Method of Disposition	er/father		Maple	Aven	ue, Loc		r, City or Town, Si Maryland 20c. Location - C	1 21	550
Baltimore, permit. Pages 1 a Department of Hei Important: If item any injury or othe		1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	D	eer Par	ck Cem	etery d Address o	of Facility St		Deer Par ineral Ho Md. 215	ome	Maryland
hite be executed from the physician and physician and street be unial-transit.		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sue to (or as a conse	Programme of):  Requence of):  RALDE	ressi	ve	such as cardiac	or respiratory arr	est,	1	Approximate Interval Between Onset and Death & DAYS
death certifications of for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tel death 3	Ectopic pre Other (spe				23d. Date Month		y Day Year
law requires that the as been signed by the 2 should be detached	b	Part II. Other significant conditions col	ntributing to death but not re	sulting in the u	nderlying ca	use given i	in Part I.	23e. Did to	bacco use contrib es 2 No 3	ute to the	
The law requate has been page 2 should	Completed				-			24a. Was a autops perform	sy prie med? dea	ere autop or to com ath? Yes 2	sy findings available pletion of cause of
OT VICE Phyaician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatier		Other	4 Nursing Ho		ence 6 Other		
or Attending frer death. virector: After n by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At I building, etc. (Spec	Injury home, farm, str	М	1 🗌 Yes	3 2 □ No	28f. Location (Si City or Town	treet and Number n, State)	or Rural	Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical Ce	29a. Certifier i Certifying Phy (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or in	h occurred a vestigation,	it the time, in my opini	date and place, on, death occur	and due to the c	ause(s) and mann ate and place, an	er as sta	ted. the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier  W. Churchept	0	10	1	License no			9d. Date signed ( APRIL		
2		30. Name and address of person who co	ompleted cause of death (Ite	om 23a) (Type,	Print) S HOP	KINS	HOSPIT	AL, BAL	APRIL NMORE, 1	MAR	YLAND
S Reais	tate trar	31. Date filed (Month, Day, Year) APR 2 2 2	32. Registrar's Sign		A PO	0					

			_ State	State of Maryland		artment of F tificate of				UL	15903
			Registrar  1. Decedent's Name (First, Middle, Last)	- <u> </u>	061	incate or	Deain	2. Date of Dea			3. Time of Death
Ħ	Physicia /Medic		Mildred V. S	haffer				Month	9, 20	Year 0 0 4	8:45p M
	Examin		4a. Facility Name (If not institution, give sta			4b. City, Town, o	r Location of Death	1	4c. County		
			Frederick Memo	rial Hospit 7. Age (In yrs. Ia:		Frede If Under 1 Year	rick If Under 24 Hrs.	8. Date of Birt	Fred		
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	put	Ì	Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	cation	<u></u>				0d. Inside City Limits
	Maryla	ļo	Maryland Frederick		deric					1	1 ∐ Yes 2 <b>X</b> ∏ No
	th the or 28a s rivili	Director	10e. Street and Number			10f. Zip Code	10/		10g. Citizen of W		try?
	s 23a	erai [	5736 Main's Lane	2. Was Decedent Ever in U.S.	12.1	217		nositu Vos es No	U.S.A		an Indian,
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show evant, the Modical Examiner must be recitified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puerti Specify:	o Rican, etc.)	Black Specify:	c, White,	
215-0036	72 ho 'natur	eted	15. Decedent's Educa (Specify only highest grade		16a. Deced (Give	lent's Usual Occup	ation during most of world)	king	16b. Kind of Bu		
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ק ק	e filed wil Il Hygien othar th	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumami	9)	
ylar	should be and Mental I smarked o	ToE	Luther	Bartgis			Ella	Rebec		Main	
Maryland 21	O 10 - 15		19a. Informant's Name/Relationship (Type Pamela Putman/ Dau				an <i>d Number or Ru</i> onal Pike				
	es 1 and 3 of Health fitam 27 i		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of natory or other place		Date	20c. Location -		
Baltimore,	Pages ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	Rest	haven	Mem Gar	May 12,	2004	Frederic	k, M	aryland
Ball	permit. Pages Department of Important: If it any injury or o		21. Signatury of Funeral Service Lieghsee	M0070		Name and Addre Keeney & O6 East C	ss of Facility Basford Church St	P.A. Fu Freder	meral H	ome cvlar	nd 21701
			23a. Part. Enter the disease, or complications, or heart failure. List only one	ations that caused the death. cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	- 7	Approximate Interval Between Onset and Death
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i	Examiner		Sequentially list conditions b.	Due to (or as a conseque	ince or).						
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O. Box	he death certifi the attending thed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	<ul> <li>c. If yes, outcome of pregnand</li> <li>1 ☐ Live birth 2 ☐ Fetal d</li> <li>4 ☐ Pregnant at time of dea</li> <li>9 ☐ Unknown</li> </ul>	leath 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year
P.O.	law requires that the de as been signed by the z 2 should be detached	by Ph	Part II. Other significant conditions conti	ibuting to death but not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to th	e cause of death?
ords	w require been sig should b		DIABETES ME	WITUS				1 🗆 Y	es 2 No	3 🗌 Proba	ably 4 Unknown
Vital Records,	e law r has be	Completed	THYPERTENSE	ON				24a. Was a autop perfor	sy pi	ere autoprior to conseath?	osy findings available inpletion of cause of
a	ician: The la certificate has rector, page 2	e Col	25. Was case referred to medical					1 ☐ Yes	2 No 1	Yes	2 □ No
	ysicia is certi	To Be	eyaminer?	spital: 1 Inpatient 2 ☐ El	R/Outpatien	t 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H	ome 5 Resid		r (Specify	)
Division of	nding Ph ath. r: After th e funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		8b. Time of Injury	28c. Injun Worl	y at k? Yes 2 □ No	28d. Describe h	ow injury occurre	d	
DIVIS	al or Atta s after de: il Diracto	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, is	edicai (	29a. Certifier (Check only one)	cien: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occur	, and due to the c rred at the time, c	cause(s) and man date and place, a	ner as stand	ated. the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier			29c. Licens	_		29d. Date signed		Day, Year)
	~		maryle He	well mo			0075	<	5/9/0	4	
	10		30. Name and address of person who com Mary P. Howell, M				ive. Fre	derick.	Marvlan	1 217	702
<b>3</b> 7	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		/	~	<b>,</b>			
10	Registr	ar .	MAY 1 8 2004	renewa	14	Ann a	- 2				

Dorothy I. Sissamend Trem #23a Per me Manual d 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2 **AKG** Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Sisson Dorothy May 6, 2004 6:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1910 Owens Road Oxon Hill Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 07/25/1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X 75 Massachusetts Yrs. 011-22-7190 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylan nand Mantal Hygiene. If Is marked other than "natural", or Itams 23a or 28a-1 show raumatic evant, Ire Madrian Examinan mant he notified at 1 Yes 2X No Maryland Prince George's Upper Marlboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 8401 Trumps Hill Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes À ANo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ¾ Tylo Specify: ģ Specify: White 3KXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Mingirulli Emily Giovannangeli ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any Injury or other traum <u>once.</u> Donna Jeffrey / Daughter 225 Willow Lake Cove Roswell Georgia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD. Veterans Cem. 05/12/2004 Cheltenham, Maryland ` 4 □ Donation ☐ Other (Specify) 22. Name and Address George P. Kalas Funeral home P.A. 21. Signature Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Enter the disease, o complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac Arrivthmia associated with Cardiomes a figure and Death disease or condition a. Attma arriving the cardiomes and Insufficiency and Insufficiency Immediate Cause (Final disease or condition resulting in death) Fnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 □ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has death 2 No Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence &XXOther (Specify) At scene Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1X Yes 2 □ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Hospital or Attending P
 A hours after death.
 Funeral Diractor; After t 28d. Describe how injury occurred Certification: Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P O.C.M.E. May 8, 2004 Strell m White 30. Name and addr-ss of person who completed cause of death (Item 23a) (Type, Print) P. KORELL MARGONIN 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Denve & Sparke ! Registrar MAY 1 8 2004

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 Month 2:37 AM **Physician** GEORGE LOUIS SPITTEL Mar /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner CARROLL WESTMINSTER CARROLL HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
OCT. 27, 1924 Birthplace (State or Foreign Country) 5 Social Security Number Days **Funeral** Hours Min. 1□M 2□F Yrs MARYLAND 79 Director 219-16-4636 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show traumatic event, the Medical Examiner must be notified at YNYes 2□No SYKESVILLE Director CARROLL MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 21784 7200 THIRD AVENUE "natural", or iteme 23a by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TYes 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEERING** 4 FINANCIAL ANALYST and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be LOUIS ALBERT SPITTEL ELLEN ELIZABETH TUGWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health as Important: If item 27 is sny injury or other traus M. LOUISE SPITTEL/WIFE SYKESVILLE, MD 7200 THIRD AVENUE, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) WESTMINSTER, MARYLAND 5/5/2004 WESTMINSTER CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 0(401 **Physician** disease or condition resulting in death) tours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has the funeral director, page 2 autopsy performe certificate 2 No 1 ☐ Yes 25 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 1 Tyes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Hospital or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 8 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box

Physici	rt j	1. Decedent's Name (First, Middle, La	st)	-		of Deati	2.	Reg. No Date of Death Month		3. Time of Death
/Media	cal	HAROL  4a. Fecility Name (If not institution, give		LMES	SMI	TH, J	K. /	YAY 3	Year  Acc 4  Ic. County of Dear	10.53 A
Examir Funeral Director	ner	HOLY CROS 5. Social Security Number 6. S	S HOSPITA	In yrs. last birthday	SIL	VER	SPRIN	5	MONT	- 0.1
3		218-20-0162 Usuel Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				1 721	10d. Inside City Limit
ified a	tor	MD Montgom	ery	Rockvi	lle					1√Yes 2□N
ma 23a or 28a-f show	Director	10e. Street and Number	7		10f. Zip (				Cilizen of What Co	ountry?
18 23a	Funeral	6005 Crawford	AVE .	er in U.S. 13.	. Was Decede	208		Yes or No-	14. Race - Ame	erican Indian,
은 본	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 1 C		If Yes, speci 1 Yes 2	ent of Hispanic C fy Cuban, Mexic No Specif		an, etc.)	Black, Whit	
ene. than "naturel", or the Medical Exam	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation a de completed) College (1-4or 5+)	(Giv-	edent's Usual e kind of work DO NOT use	done during me	ost of working	16b.	Kind of Business	/Industry
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ked o	To Be	Harold C. Smit				Mar	ie Smi	th		
is ma		19a. Informant's Name/Relationship	Type, Print)						or Town, State, 2	
f Health item 27 other tr	100	Edwin B Smith  20a. Method of Disposition	son	1710 20b. Place of Disp cemetery, cre		kinson	Rd F		ille, M Location - City or	ID 20837 Town, Slate
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Departme Importar any injur		21. Signature of Funeral Service Lice		4	22. Name and	Address of Fac	Holt	on Fun	eral Ho	me
nysician Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	RATORY			as cardiac or re	spiratory arrest,	rnesvil	Interval Between Onset and Death
xaminer	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	FAIL (consequence of):	AVAROUS					YEARS
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n signed b uld be deta	b	Part II. Other significant conditions	contributing to death but i	nol resulting in the	underlying ca	use given in Par	t I.	_		the cause of death?
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0 -	Be	25. Was case referred to medical examiner?	Hospital:			Other	ce of Death (C	110000		
certif	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time	of 28	Bc. Injury at		5 Residence Describe how in	6 Other (Spe jury occurred	cify)
er this certificate eral director, pag	ō	1 Najural 5 Pending 2 Accident investigation	De Blace of Injune	- At home, farm, s	М	Work? 1 ☐ Yes 2 [		Location (Street City or Town, Sta	and Number or Ri	ural Route Number,
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		•	State Registrar		Cei	tificate	e of E	eath			leg. No.	2009	10301
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	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or	Location of	Death		4c.	County of Deet	
			Beverly Health Car				erst		4 Hrs. Lo.	S : (S:#)		Vashing	
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$	7. Age (In yrs. 91	Yrs.	If Under Months	Days	Hours	Min.	Date of Birth (Month, Day arch 2	(, Year)		hplace (State or Foreign untry) ryland
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	death with the Maryland ms 23a or 28a-f show r must be notified at	o			illiam								1 ∑ Yes 2 □ No
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	h with	al D	49 E. Frederick St	reet			21	795			U.	S.A.	
	deat	Funeral		2. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Deced	ent of His	spanic Origi n, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)	1	14. Race - Ame Black, White	
36	should be filed within 72 hours after death with the Marylan to Mental Hygiene. marked other than "natural", or Rems 23s or 28s-f show marked other than "natural", or Items 23s or 28s-f show imatic event, the Mudical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1□ Yes 2						Specify: Wh	ite
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212	nn ng	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of woi DO NOT us	rk done di se retired)	uring most o	of working				
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Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic es		Brenda Jones - Gra		1		,	Aven				, Md. 2	
<u>5</u>	Heal Heal tem 2		20a. Method of Disposition	20b. P	Place of Disponentery, cres				Date	•		cation - City or	
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Ö.	Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	by Physiclan/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown		Other (sp						Month	Day Year
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Division of Vital Records, P.O.	or Atte fter des directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st	reet, factory	, office		28f	. Location (S City or Tow			ıral Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  Fo the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier 1 Certifying Phys	sician: To the best of my knoner: On the basis of examina	owledge, deat	h occurred	at the tim	e, date and	I place, and	due to the o	cause(s)	and manner as	stated.
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			Lange Lead	9 Horls.				365		1	4. 2		
	40		30. Name and address of person who co	ompleted cause ordeath (ter	n 23a) (Tvne								
	•		MANZAR 3	SHAP 368-	mill	Stre	et-	Hage	stour	ii (	MO	21740	)
	Sta		30. Name and address of person who come in the company of the comp	32. Registrar's Signa	ature	redi	,						
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			1 - For Stata Registrar	State of M	larylar		artmen rtificat			and M		g. No. 20	04	15900
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	Examin		4a. Facility Name (If not institution, giv     5. Social Security Number 6. S	16425 Calla 1	Hill	last birthday)	4b. City,	1 Year	Location of	Mt. Sa		4c. County of	Alle	egany ace (State or Foreign
	Funeral Director			<b>X</b> M 2□ F	77	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, August 2			ace (State or Foreign ry)  Maryland
	the Maryla 28a-f shov	ector		legany	100.01		10f. Zip	Code	Mt. Sa	vage	10	g. Citizen of Wh		Od. Inside City Limits  1 Yes 2 No
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036	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If itam 27 is markad othar than "natural", or Itams 23a or 28a-1 show any injury or othar traumatic avant. If a Modical Extending the routiling at 2008.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ▼Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates	No ?	i	Was Deced If Yes, spec	. /			ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:		an Indian,
21215-0036	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	rk done d	du <i>ring m</i> osi ')		ing 1	6b. Kind of Busi		ustry
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ary	2 shou and M Is mar aumat		19a. Informant's Name/Relationship (			19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	A Route Number,		ate, Zip	Code)
	Pagas 1 and 2 nent of Health int: If itam 27 I iry or othar tre		Reginia Waite  20a. Method of Disposition  1 □ Burial 2 🏋 Cremation 3 □			Place of Dispo	osition (Nar matory or o	ne of	-		II. Mt. Savai Date 2 May 04,	e. Md. 215 0c. Location - Ci		νπ, State
Baltimore,	permit. Pag Department Important: any injury o		14 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	y)			erland ( 2. Name an	d Addres	s of Facilit		zie Funeral I			Maryland Main
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Division	or or Dir	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of I	njury - At h etc. <i>(Specil</i>	ome, farm, str	eet, factory	, office		1	28f. Location (Stre City or Town,	et and Number State)	or Rural	Route Number,
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	MLS		30. Name and address of person who	completed cause of	death (Iter		Print)		2	1. 1	and, n	1n 71-		
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 5 200	32. Regis	trar's Signa	Seton ature	for	ve,	/ CUM	587/	muck, Pr	10 2/3	0_)	-

State of Maryland / Department of Health and Mental Hygiene

			State of Marylane /	Certificate of Death		Reg. No. 2 ()	04	15909
			1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	Yeer	3. Time of Death
	Physiciai /Medica		GEORGE FRANCIS SIMPSON	A	PRIL	$27^{\text{pay}}$ 2	004	6:55 PM
**	Examine		4a Facility Name (If not institution, give street and number)	4b. City, Town, or Loc				
-/		8	DEVLIN MANOR NURSING HOME	CUMBERL			EGAN	Y
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last in 217–10–4699 81 M 2□ F 91	birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birt Month, De EB • 8,	1913	9. Birthp Coun MARY	lace (Stete or Foreign try) 'LAND
	pu 🛾	-	Usual Residence of Decedent         10b. County         10c. City, To	own or Location			1	0d. Inside City Limits
	arylan show	_		BERLAND			'	1 XYes 2 □ No
	the Maryla 28a-f sho	ğ	10e. Street and Number	10f. Zip Code		10g. Citizen of V	What Coun	tn/
	23a or	Funeral Director	350 BEDFORD STREET	21502		U.S.	Α.	•
020	urs a	ਨੂ∣	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	eify Yes or No- lican, etc.)	Specify		etc. ITE
5-0	"natural",	etec	15. Decedent's Education (Specify only highest grede completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of working	g	16b. Kind of Bu	siness/ind	dustry
2121	⊆ ₫	Completed	Florenters/Conneders (0.10) College (1.4or Fr)	(Give kind of work done during most of working life. DO NOT use retired) CHEMICAL DI- CHEICAL DI-STILLMAN	STILLMAN	CORPORA	TION	oeko
Maryland 21215-0020	d out	o Re	17. Father's Name (First, Middle, Lest) CHARLES FRANCIS SIMPSON	18. Mother's Name BERTHA M				
	2 8 8 2	7		9b. Mailing Address (Street and Number or Rurel 120 FAYETTE STREET, CUM			Stete, Zip 21502	
Baltimore,	oernit. Pages 1 an Department of Heat mportant: If item 2 any Injury or other pnce.		Zoa. Metriod di Disposition	of Disposition (Name of tery, crematory or other place) PETER & PAUL CEMETERY O	Date 5/03/200	20c. Location ·	-	wn, State VD, MD
Balt	permit. Pag Department Important: I any Injury o pnce.		21. Signature of Funeral Service Licensee	OPCHURCH FUNERAL HO 202 GREENE ST., CUM			21502	2
		1	23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Shook, of Hour failule. Elst only one square of source.					Onset and Death
d	/Medical		Immediate Cause (Final disease or condition	Condumygraty			į	Mean
п	Examiner		resulting in death)  a. Due to (or as	a consequence of):			i	1
	₽ #		atherne	luona			i i	ucan
68760,	certificate be executed nding physician and use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	a consequence of): a consequence of):			/	
Box 68	S D S	Z ed	resulting in death) Last				3	
-	deat	by Physician	Part II. Other significent conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did t	obecco use cor	ntribute to	the cause of death?
P.0	at the	ב ב	serve anter storar strong	4-	10	Yes 2 No	3 🗆 Prob	ably 4 Unknown
	s that	2	sexun aprile service str					
Records,	law requires that the death as been signed by the atter 2 should be detached for i	Completed			24a. Was perfo	an autopsy med?	ava	ere autopsy findings ailable prior to apletion of cause deeth?
	The law	E			101	100 20 No	10	Yes 2LINe
of Vital	ician: The	De	25. Was case referred to medical	26. Place of Death	Check only o	ne)		
>	Physician: this certific ral director,	0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Other: 4 Nursing Hom	e 5∐Resid	dence 6 Oth	er (Specify	<i>'</i> )
0	g Physe er this neral di		27. Manner of Death 28a. Date of Injury 28b		Bd. Describe h	now injury occurr	ed	
0	Attending Fir death.  sctor: After by the funer	120	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	M 1 Yes 2 No				
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral complete of the funeral	edical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	Bf. Location (S City or Tow	Street and Numb vn, State)	er or Rure	l Route Number,
	spital ours	١	29e Certifier NC Certifying Physician: To the best of my knowled	ge death apparted at the tirre, date and starse an	nd dus to th≥ r	nausa(s) and na	rinar as sh	thad
	24 h		(Check only one)  2 Medical Examiner: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occurred	d at the time,	date and place,	and due to	the cause(s)
	Vithin omp.		29b. Signature and title of certifier	29c. License number		29d. Date signed		-
			Mollin ho	D0017565		apr.	28,2	004
	7		30. Name and address of person who completed cause of deeth (Item 23a	a) (Type, Print)				
	MRS		AJBOILTHO NO 912 No	<u> </u>	7	215	0 2	
	State Registra	e r	31. Date filed (Month, Day, Year)  MAY 0 6 2004	Sparks				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:20 A Virginia Sharrer April 29 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 406 Pearl Street Frederick Frederick

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1:□ M 2⊠ F 84 2, 1919 Maryland Director 218-10-2377 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other fraumatic event, the Medical Exuritive must be notified at once. 10a State 10b. County XvYes 2 □ No Directo Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 406 Pearl Street 21701 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Crossing Guard 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irving J.H. Shankle Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 406 Pearl Street Frederick, Maryland 21701 / spouse Kenneth M. Sharrer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 5/3/04 Frederick, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arte Cardiovasa 105cle /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed ۾ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☑ No Isthma Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has rmed2 this certificate 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatore and title of certifier April 30,2004 D35164

Registrar

DHMH 17 Rev 1/2001

10

State

West

7th Street Frederick. MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Jr.

15

32. Registrar's Signature

Andrew ZARick

MAY

31. Date filed (Month, Day, Year)

MD Frederick  10e. Street and Number 1200 Aynsley Ct.  11. Marital Status 1	TAL FRI st birthday) If Under Yrs.  Town or Location Frede  101. Zi  13. Was Dece If Yes, spi 1 Yes, spi 1 Yes, spi 1 Nomem  19b. Mailing Addres 1200 Ay the Control of Mailing Addres 1200 Ay The Control of Mailing Addres 1	rick ip Code 21703 edent of Hispanic Oriectly Cuban, Mexican 252 No Specify: ual Occupation nork done during mos use retired) aker  18. Mothe Ne ss (Street and Numbe nsley Ct ame of other place) metery 4 and Address of Facult Id B. Th ode of dying, such as	as Date of July  ligin? (Specify Yes on n, Puerto Rican, etc.)  st of working  er's Name (First, Mice ttie Jace or Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural R	Birth Day Year)  10g. Citi  10g. Citi  No-  16b. Ki  O  cobs  mber, City of ci	County of Death FREDERIC 1950  10  10  10  10  10  10  10  10  10	d. Inside City Limit  1 GYes 2 N  N  N  N  N  N  N  N  N  N  N  N  N
4a. Facility Name (If not institution, give street and number)  FREDERICK MEMORIAL HOSPIT  5. Social Security Number  217-56-0156  Usual Residence of Decedent  10a. State  10b. County  MD Frederick  10e. Street and Number  1200 Aynsley Ct.  11. Marital Status  1   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never Married   Never or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)   College (1-4or 5+)  8  17. Father's Name (First, Middle, Last)  Robert Harding  19a. Informant's Name/Relationship (Type, Print)  Carroll Summers (Husband)  20a. Method of Disposition  1	TAL FRI st birthday) If Under Yrs.  Town or Location Frede  101. Zi  13. Was Dece If Yes, spi 1 Yes, spi 1 Yes, spi 1 Nomem  19b. Mailing Addres 1200 Ay the Control of Mailing Addres 1200 Ay The Control of Mailing Addres 1	rick ip Code 21703 edent of Hispanic Oriectly Cuban, Mexicar 22 No Specify:  ual Occupation most done during most use retired) aker  18. Mother Ne ss (Street and Number of other place) metery 4 and Address of Facult Id B. Th. Main Stock of dying, such as	igin? (Specify Yes on Puerto Rican, etc.  st of working  ettie Jac er or Rural Route Nu co, Frede 4/24/04  tompson to Mide cardiac or respirato	Birth Day Year)  10g. Citi  No-  16b. Ki  Odle, Maiden  Cobs  mber, City of  rick  20c. Lo  Mye  Funer  Heto	County of Death FREDERIC 9. Birthple 1950  10  10  10  10  10  11  11  12  14. Race - America Black, White, e Specify: Whi ind of Business/India  White Manager of the Sumame)  or Town, State, Zip (1) cation - City or Tow rsville al Home why, Mi)	CK  MD  d. Inside City Limit  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
FREDERICK MEMORIAL HOSPIT  5. Social Security Number 217-56-0156  Usual Residence of Decedent 10a State 10b. County 10c. City, 10c. Street and Number 1200 Aynsley Ct.  11. Marital Status 1 Never Married 1 Married 3 Widowed 1 Divorced 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) Robert Harding 19a. Informant's Name/Relationship (Type, Print) Carroll Summers (Husband) 20a. Method of Disposition 1 Burias 2 Cremation 3 Removal from State 1 Day Burias 2 Cremation 3 Removal from State 1 Sequentially list conditions, and is a summer of the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or complications that cluss the death, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or conditions resulting in death)  Sequentially list conditions, and to immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and to immediate Cause (Final disease or conditions)  Lause. Enter Underlying Cause (Disease or injury that intiated events resulting in death)  Sequentially list conditions, and to immediate Cause (Final disease or conditions)  Lause. Enter Underlying Cause (Disease or injury that intiated events resulting in death)  Sequentially list conditions, and to immediate Cause (Final disease or conditions)  Lause. Enter Underlying Cause (Disease or injury that intiated events resulting in death)  Part Herborn Alexandric Cause (Final disease or conditions)  Lause. Enter Underlying Cause (Disease or injury that intiated events resulting in death)  Part Herborn Alexandric Cause (Final disease or conditions)  Lause Enter Underlying Cause (Disease or injury that intiated events resulting in death)  Lause Enter Underlying Cause (Disease or injury that intiated events resulting in death)  Lause Enter Underlying Cause (Disease or injury that intiated events resulting in death)  Lause Enter Underlying Cause (Disease or injury tha	Town or Location Frede  101. Zi  13. Was Decci If Yes, sp. 1 Yes  16a. Decedent's Usi (Give kind of wild) (Give kind of wild) homem  19b. Mailing Address 1200 Ay: 100. Zi  100. Zi  11	rick ip Code 21703  edent of Hispanic Oriectly Cuban, Mexicar 2 No Specify:  ual Occupation most done during most user retired)  aker  18. Mother Ne ss (Street and Number of other place) metery 4  and Address of Facult Id B. Th. and Address of Facult Main Stock of dying, such as	Min. July  igin? (Specify Yes of the control of the	10g. Citi 10g. Citi 10g. Citi 16b. Ki 0 dle, Maiden 20bs mber, City of 20c. Lc Mye Tuner	9. Birthold Count.  1950  10  10  11  11  12  14. Race - America Black, White, et Black, White, et Black, White, et Specify: Whi ind of Business/India (Wn home Sumame)  10 Town, State, Zip (1)  11  12  13  14. Race - America Black, White, et Specify: Whi ind of Business/India (India )  15  16  17  18  19  10  10  10  10  10  10  10  10  10	ince (State or Foreign D)  d. Inside City Limit  1  Yes 2 N  N  N  N  N  N  N  N  N  N  N  N  N
Usual Residence of Decedent  10a. State  10b. County  MD  Frederick  10e. Street and Number  1200 Aynsley Ct.  11. Marital Status  1 Never Married	Town or Location Frede  101. Zi  13. Was Dece If Yes, sp. 1 Yes  16a. Decedent's Ust (Give kind of wife). Do NOT homem  19b. Mailing Address 1200 Ay: 10c of Disposition (Nametery, cremator, or rmony Cermony	rick ip Code 21703  edent of Hispanic Oriecity Cuban, Mexicar 2 No Specify:  ual Occupation rork done during mos use retired)  aker  18. Mothe Ne ss (Street and Number nsley Ct ame of other place) metery 4  and Address of Facult Id B. Th and of Jung, such as	Min. July  igin? (Specify Yes of the control of the	10g. Citi  10g. Citi  10g. Citi  16b. Ki  O  cobs  mber, City o  crick  20c. Lc  Mye  Funer	izen of What Count USA  14. Race - America Black, White, e Specify: Whi ind of Business/Indi wn home Sumame)  or Town, State, Zip o , MD 21 coation - City or Tow rsville al Home wn, MD	d. Inside City Limit  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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Part II. Ditter significant conditions contributing to dealir out not result						
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Covonay arrey do	seare		24a. V	as an atopsy	24b. Were autop:	sy findings availab
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O 1 Ves 2 No Hospital: 1 net 2 El			ursing Home 5 R			
1 X Natural 5 Pending (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		oe how injur	у оссиггөа	
27. Manner of Death    X   Natural   5   Pending   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   28e. Place of Injury - At hombuilding, etc. (Specify)			28f. Locatio	n (Street and Town, State	nd Number or Rural	Route Number,
29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowl one in the basis of examination and manner stated.	on and/or investigatio	n, in my opinion, dea	th occurred at the tir	ne, date and	d place, and due to t	he cause(s)
29b. Signature and title of certifier	29	9c. License number		29d. Dat	te signed (Month, D	ay, Year)
mony		D4716	59	4	121/09	
30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)			0.45	21716	

State of Maryland / Department of Health and Mental Hygiene Figure Amend #5, per FH, FCHD, SL, 5/6/04 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May **Physician** 2004 JAMES EDWARD TURNER, JR. 3:05 Ам /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 28, 1916 9. Birthplace (State or Foreign West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 231-10-6708 234-01-6708 Usuel Residence of Decedent 1XM 2□F 88 Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 East 16th Street 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Refrigeration & Air Condition Fort Detrick 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Edward Turner, Sr. Ada Shickle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janice Lawson (Daughter) 6122 Elaine Drive, Jefferson, Maryland 21755 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 5/5/04 Frederick, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal are of Funeyal Service L ROBERT E. DAILEY & SON FUNERAL HOMES, 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Pert1. Enter the disease or complications that caused shock or heart fallure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 igned by the attending physician be detached for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. signed by the 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Som mil MD 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Ave, Suite e3, Freder OLL HO MD. 801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Physici		1. Decedent's Name (First, Middle, Last  Daniel L.	,	Walker			2. Date of Death May 3, 20		3. Time of Death
/Medic Examin		4e. Facility Name (If not institution, give	street and number)			or Location of Deat	h	4c. County of Allegany	
		39 Blair Street 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	Frostbur	If Under 24 Hrs	8. Date of Birth		Birthplace (State or Fore
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or 28a-f	Funeral Director	10e. Street and Number			10f. Zip Code	04500	109	g. Citizen of Wha	at Country?
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lical E	eted	15. Decedent's Edu (Specify only highest grad	cation	16a, Dece	dent's Usual Occup	pation	rking 16	6b. Kind of Busin	ess/industry
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od othe	To Be Co	17. Father's Name (First, Middle, Last) George S. Walke	ər	Iviante	marros m	18. Mother's Nar	me (First, Middle, Ma Winters W	aiden Sumame)	
trauma		19a. Informant's Name/Relationship (T) Wilda Walker	<sub>vpe, Print)</sub> wife	19b. Maili 39 E	ng Address (Street Blair Stree	and Number or Ru	ural Route Number. C	City or Town, Sta LITG	<sup>te, Zi</sup> MD <sup>e)</sup> 2153
or other		20a. Method of Disposition 1 Burial 2 Cremation 3 F		20b. Place of Dispo cemetery, crei Frostburg N	sition (Name of patory or other place lemorial Pa	rk		C. Location - City Frostburg	
Important: If ite any injury or ot once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> <li>Nicholas J. Scarpe</li> </ul>	99		· NamSeafeel	†iPonëval ⊦			
sician ledical aminer	er.	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. LIVER  Due to (or as a	FAILURE consequence of): CIRRHOSIS consequence of):	or the mode of dyn	ig, such as calular	to respiratory arres		Approximate Interval Between Onset and Death
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icate has been s r, page 2 should	Completed	CORONARY ARTERY D	ISEASE, DI	ABETES			24a. Was an autopsy performe	prior	
is certificate director, pag	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient	t 2□ER/Outpatien	t 3 DOA Oth		ath Check on one		0
Alter th funeral	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		28c. Injur Wor	y at	28d. escr how	ce 6 Other (S	эр <del>ө</del> спу)
To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injunder building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number o State)	r Rural Route Number,
the Funeral mpletely filled	edical C	29a. Certifier (Check only one) Certifying Phy	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	and due to the causered at the time, date	se(s) and manne e and place, and	r as stated. due to the cause(s)
To th	Me	29b. Signature and title of certifier	7	101	29c. Licens	9 number D13601		Date signed (M	lonth, Day, Year)

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ral tor		5. Social Security N 216–50–2982		.Sex 1 <b>∑X</b> M 2⊡ I		'In yrs. last bii		Inder 1 Year nths Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/15/19	th <i>y, Year)</i> <b>249</b>		9. Birthp Cour Mary	place (State or Fi ntry) land
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RICHARD  RAJON Part of Control controlling pre-served server provided   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian of Casps   Ac City, Town or Laussian or Laussian   Ac City, Town or Laussia				1. Decedent's Name (First, Middle, L	ast)									Voor	3. Time o	of Death
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Social Security Number   Sec				4a. Facility Name (If not institution, g	ive street and number)	)		4b. City,	Town, or	Location o	of Death		4c. Cou	inty of Death		
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1601 Pennsylvania Ave. Hagerstown, MD 21742   23a. Part Life for disease, or complication of the caused the death. Do not refer the mode of dying, such as cardiac or respiratory arrest. Control of the complete cause (Final disease or condition)   1600 Pennsylvania Ave. Hagerstown, MD 21742   23a. Part Life for disease, or complete caused (Final disease or condition)   1600 Pennsylvania Ave. Hagerstown, MD 21742   23a. Part Life for disease, or condition of the caused of death of the conditions of the caused (Final disease or condition)   1600 Pennsylvania Ave. Hagerstown, MD 21742   23a. Part Life for disease, or condition of the caused of death of the cau	<u>ā</u>	uld by Aenta rked ric e		Richard West						Mary	Woo	dy				
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Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 3   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)    23d. Date of delivery Month Day Year 4   Pregnant at time of death 5   Other (specify)    23d. Date of delivery Month Day Year 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   End of the live birth 3   Ectopic pregnancy 4   Pregnancy 1   Live birth 2   End of the live birth 3   Ectopic pregnancy 4   End of the live birth 3   Ectopic pregnancy 4   End of the live birth 3   Ectopic pregnancy 4   End of the live birth 3   Ectopic pregnancy 4   End of the live birth 3   Ectopic pregnancy 1   End of the live birth 3   Ectopic pregnancy 1   End of the live birth 3   Ectopic pregnancy 1   End of the live birth 3   Ectopic pregnancy 1   End of the live birth 3   Ectopic pregnancy 1   End of the live birth 3   Ectopic pregnancy 1   End of the live birth 4   End of the live birth 4   End of the live birth 4   End of the live birth 4   End of the live birth 4   End of the live birth		/Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a conseque	ence of):								Interval Be Onset and	tween Death
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State 31. Date filed (Month, Mark 747) 2004 32. Registrar's Signature	,	LX		30. Name and address of person wh	no completed cause of	death (Item 2	23a) (Type.	Print)	190		-				-	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Mary B. Wanless 10:40 a.m. 2004 April /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany County Nursing Home Cumberland

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2√ F Yrs. 89 Director 217-10-5098 West Virginia April 2, 1915 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f ahow 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County Items 23s or 28s-f show iver must be notified at 1 TYPes 2 □ No Director Maryland Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 628 Brookfield Ave. 21502 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 N Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager **Book Company** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Preston Bennett Zettie (Kisamore) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Walizer/Daughter 611 St. Marys Ave., Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò North Fork Cemetery 5/1/04 Riverton, WV injury 22. Name and Address of Facility 21. Signature of Fyine al Service Licensee Kight Funeral Home d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hine. 23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical MYELODYSPLASI ONS Examiner Due to (or as a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attanding Physician: The law requiras that the daath certificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attanding physicien end completaly filled in by the funeral director, page 2 should be detached for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of pertifier 5 wano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MLS 500 Memorial Ave., Cumberland, MD 21502 Robustiano J. Barrera, M. I 31. Date filed (Month, Day, Year) APR 2 7 2004 D State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #8, perFH, FCHD, s1, 5/4/04 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2:00A M + sabelle ELIZABETH WILLIAMS 2004 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Manor NUVSING HIME Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2**7**F 93 216-22-8083 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28s-f show Md. 1 Yes 2 No Myersville REDERUCK Director 10f. Zip Code 10g. Citizen of What Country? ms 23a or Harmon USA 10310 21773 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after d nent of health and Mentall Hygiene.

The filem 27 is marked other than "naturel", or Item may or other traumatic event, "I'm Medical Examination ☐Yes 2 No 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1□ Yes 2☑ No 3 Widowed 4 □ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home House wife 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ASKINS Bacon Mary George 19a, Inform s Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is 10310 Harmony (day) Rd. Myersville Md. 21713 HILDA WILLIAMS 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition Important: If it eny injury or o once. 1 Burial 2 Cremation 3 Removal from State MAY 4, 2004 Bushy Park \* 4 ☐ Donation 5 ☐ Other (Specify) Cem. 21. Signal e of Funeral Service Circusee permit. 22. Name and Address of Facility ARLI KOLLINS FUNERAL HORE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 70 IHRIVE **Physician** ALLUBE /Medical Due to (or as a consequence of) **Examiner** ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) sician a Box 68760. Physician/Medical phys as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2UNo page this certificate 1 🗆 Yes 2 🗌 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à within 24 hours a To the Funeral L Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Dey, Year) -03 M.10 WHEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REDERICK MD 21701 KAZMI, 814 TOLL HOUSE AUE SIBTE A Mp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	ecation					10d. Inside City Limit
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r dez	ne	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of I	Hispanic Origin? (Spe pan, Mexican, Puerto I	cify Yes or No-		14. Race - Amer Black, White	
within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28a-f show ite Madical Examiner must be notified at	by Fi	1 X Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1	1 ☐ Yes 2 🕱 No					hite
72 hor	eted	15. Decedent (Specify only highes	s Education	16a.	Dece	dent's Usual Occup	pation during most of workind)		16b, Ki	nd of Business/I	ndustry
of 2 should be filed within 72 hours aft the and Mantal Hygiene.  27 Is marked other than "natural", or traumatic event, the Mudical Event.	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5			bo NOT use retire ther	dd)		Publ	lic Educ	ation
othe sant,	e C	17. Father's Name (First, Middle, I	ast)				18. Mother's Name				
Wents Wents ific e	0	Otto Geo	rge	Woerne	r		Cora	William	n	Kes	sel
2 sho and 1		19a. Informant's Name/Relationsh		19b.	Mailir	ng Address (Street	and Number or Rura	Route Number	, City o	r Town, State, Zi	p Code)
and and m 27	į.	Mrs Carol A. Mo	ran/Niece	20	1 H	lutter Av	enue, Fisl	ner, Wes	st V	<sup>7</sup> irginia	268 <b>1</b> 8
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 le marked other than "natural", or Itama 23e or 28a-f ehow any injury or other traumatic event, the Markeal Examinat must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp.				sition (Name of natory or other pla 2 Cremat	ory May 7			thsbure	own, State , Maryland
permit. Departin Importe any inju		21. Signature of Funeral Service L	U(1)	M00706			& Basford Church Stre		ıņer	al Home	, rary rark
		23a. Part 1. Enter the disease, or a shock, or hear railure. List of			ot ent	or the mode of dying	nurch Stre	respiratory arr	eder est,	ick, Ma	Approximate
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a. Hyperte	ni (	1 1	mul ()	nun Con	Lit	100	Mou	Interval Between Onset and Death
/Medical Examiner		( )	Due to (or as	a consequence o	f):		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		U
pe isi	Examiner	Sequentially list conditions, it any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	а сопзециенсе о	l):						
be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	f);						
ite be nysicia ne bur	Cal		d								
entifica ling ph e as ti	Med	IF FEMALE:		_					-		
death certific a attending p d for use as i	ruysician/med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No.	4☐Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)	/		2	3d. Date of deliv Month	ery Day Year
that the de ad by the detached	3	9 Unknown	9□ Unknown								
The law requires that the death certificate has been signed by the attending proge 2 should be detached for use as the contraction of the contract	2	Part II. Other significant condition	s contributing to death b	ut not resulting in	the ur	iderlying cause giv	en in Part I.	1	acco us		he cause of death?
w require been si should b	בוב										
	combieren							24a. Was ar autops perform	red?	prior to co death?	ppsy findings available mpletion of cause of
certificate	ט	25. Was case referred to medical examiner?					26. Place of Death				
Physicia this cert al direct	2	1XXes 2 No		nt 2□ER/Out	_	3□ DOA Oth	4 - Nuising Hom	e 5 ☐ Reside	nce 6	Other (Specif	At scene
or Attending Physician: after death. Director: Atter this certification by the funeral director.	alloi.	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigs		Year) In	me of jury	28c. Injury Wor M 1	y at k?	Sd. Describe ho	w injury	occurred	in hethhat
l or Atte after de: Diracto		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be	urv - At home, fam		et, factory, office	28			Number or Rura	Il Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate

within 24 hours after death. To the Funeral Director: A

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

O.C.M.E

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

April 29,2004

Registrar

Medical

31. Date filed (Month, Day, Year) State

32. Registrar's Signature 2004

			1 - For State Registrar	State of Marylar		artment of H			iene a. No. 2004	15919
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last, Helen Sn 4a. Fecility Neme (If not institution, give	nith W	'ebb	4b. City. Town. o	or Location of Dee	2. Date of Death		
	Funeral Director	ilei	5520 B Bunk. 5. Social Security Number 6. Sec	ttsville				le Md.	Frederi	. 4
	death with the Maryland ims 23s or 28e-f show	Director	Usuel Residence of Decedent  10a. State 10b. County Freder(  10e. Street and Number		ity. Town or Lo	ts ville				10d. tnside City Limits 1'XXYes 2 □'No
	s 23a or	eral Dir	5520 B Bur	tittsville		10f. Zip Code 3 171			og. Citizen of What Co	
5-0036	hours after de turel', or Itam el Exeral er r	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of F Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puel Specity:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Bleck, White Specify: W/	
21215-(	within 72 ene. then "ner	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	ent's Usual Occup kind of work done DO NOT use retired nemethe	during most of wo d)	irking	6b. Kind of Business/1 House wife	•
Maryland	S should be filed and Mental Hygi Is marked other aumatic svent, II	To Be	17. Father's Name (First, Middle, Last)  Rubert Free  19a. Informant's Name/Relationship (Ty,	lerick Sm		Address /Street	Gerti		aiden Sumame)  CL ncL PC  City or Town, State, Z.	
	iges 1 and 2 s it of Health ar it itsm 27 is or other trau		Helen Va-Dinh =  20a. Method of Disposition  1 Burial 2 Commation 3 DR	Daughter 200.	553 Place of Dispos	OBBUr	Hittsu.	Date 2	Oc. Location - City or T	114 1118 own, State
Baltimore	permit. Pages Department of Important: If I any injury or once.		*4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License	17a	1 22	Name and Addre	an of Condin.			unswick Md.
	Physician /Medical Examiner	er	23a. Pert1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, the leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	juence of):	or the mode of dyin	g, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dicai Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	·				
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	l death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause give	en in Part I.		cco use contribute to I	he cause of death?
		Completed						24a. Was an autopsy performe	prior to co death?	ppsy findings available impletion of cause of
V.	Physician: 1 this certifical	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	ospital:	ER/Outpatient	317 DOA Othe	_	th Check on one		
Division of		$\vdash$	27. Manner of Death  DENatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	28c. injury Work	4 🗆 Nursing n	28d. Describe how	ce 6 Other (Special injury occurred	ý) 
Divis	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	v)			City or Town,		
	ns Hospitel 124 hours a 18 Funeral I	edical	(Crock only 2 Medical Examin	cian: To the best of my kno or. On the basis of examina and manner stated.	wiedge, death	occurred at the tim isagadon, in my op	e, date and place pinion, death occu	, and due to the cau- rred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	To the To the Complet	M	29b. Signature and title of certifier	MID.		29c. License		I	Date signed (Month,	* * * * * * * * * * * * * * * * * * * *
4	5		30. Name and address of person who con				m Au	1200	INSW SI	m21216
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		610 9	170	C, DKV	14-01-01	1/6

				Please	Type or Prin				. Ensure A lealth and I	_		_	
			1 - State Registrar		Otate of Mi	ar y tarre	•	tificate of		R	eg. No.	2004	
	Physici /Medic		1. Decedent's Name LINA	e <i>(First, Middl</i> e, La HELENE		ATES				2. Date of Dea Month MAY 3	Day	04 Year	3. Time of Death 6:30 A M
	Examin				e street and number)			,	or Location of Death			County of Dea	
	Funeral		5. Social Security N	RQUE STRE	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		1	INCE GE	thplace (State or Foreign ountry)
22	Director		578-82-00 Usual Residence of	005	I□M 20XF {	33	Yrs.	World Days	110013	March 10		921 Ger	rmany
	yland		10a. State	10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
	8e-f si	Director	MD	Prince G	George's	Cap	ital F	leights_		<del>-</del>	O- Citi		1 ☐ Yes 2 🐧 No
	d within 72 hours after death with the Maryland jiene. I then - natural; or Items 23a or 28e-f show If a Medical Examiner must be notified at		10e. Street and Nu		.+			10f. Zip Code 20743				izen of What Co	•
	death	Funeral	4303 Tore	que stree	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit	erican Indian,
9	s after , or Ite	by Fu	1 ☐ Never Marr 3 🛣 Widowed	ied 2 Married	1 ☐ Yes 2 🕅 1 If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🛣 No		, , , , , , , , , , , , , , , , , , , ,		Specify:	nite
21215-0036	2 hour	ted b	A	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	oation during most of wor	tking	16b. Ki	ind of Business	
21	within 72 ene. then nai	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retire	d)	A " 'g	0	un Hama	
2	T S H	e Co	17. Father's Name	(First, Middle, Last	)		ПОП	emaker	18. Mother's Nar	ne (First, Middle,		n Home_ Sumame)	
/lan	0 0 0	To Be	Weissbin	der Karl	Huxhorn				Anna N	Marie Keu	ıch1	er	
Maryland	and and sand		19a. Informant's N		•				and Number or Ru				
	1 an Heal tem 2		Nancy Ya 20a. Method of Dis		iter	20b. Pla	ace of Dispo	sition (Name of natory or other pla	Street, (	Date Date	e1g 20c. Lo	hts ML ocation - City or	20743 Town, State
altimore,	Pages nent of ant: If It			☐ Cremation 3 ☐ 5 ☐ Other (Special	□Removal from State fy)	1			7 Cem. 05	-26-2004	Ar	lington	• VA
Balt	permit. Pages Department of Important: If II eny injury or once.		21. Signature of F	1111.	()		H	2. Name and Addre	eral Home	3			
	20200		23a. Part1. Enter t	the disease, or com	aplications that caused	the death.	. Do not ent	er the mode of dyli	156, Wald	orf, MD or respiratory are	206 est,	04	Approximate Interval Between
100	Pnysician		Immediate Cause disease or condition	(Final	one cause on each li	Pm)	(KH)	617 A	rerosi	CLOS	IS		Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as		ence of):	- 27	TIVEF	3			771
	* 日	er	Sequentially list co	enditions, nmediate	b. Due to (or as	a consequ		BUTIENG	TIKK	u un on	/H +	DIZ.	MAZE V JA
	acuied ind transit	Examin	cause. Enter Under Cause (Disease or that initiated events resulting in death)	injurý s	C						_	J	
,60	be executed sician and burial-tran	a	rosulting in county		Due to (or as	a consequ	ence or).						
687	death certificate t e attending physi d for use as the t	Physician/Medic			č d								
Box	ath cer ttendir or use	ian/N	IF FEMALE: 23b. Was deceden in the past 12		23c. If yes, outcome	2 Fetel	death 3	Ectopic pregnanc	у		1	23d. Date of de Month	livery Day Year
O.		ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4☐Pregnant at 9☐ Unknown	time or de	atn 5	Other (specify) _					
S, D	90	by Pł	Part II. Other signi	ficant conditions	contributing to death b	ut not resu	lting in the u	nderlying cause giv	ven in Part I.				o the cause of death?
ord	w require been si should t											□No 3□P	
Rec	The law ate has t page 2 s	Completed					· · · · · · · · · · · · · · · · · · ·			24a. Was a autop: perfor		prior to	utopsy findings available completion of cause of
Division of Vital Records,		Be C	25. Was case reference examiner?	rred to medical	gn-2-2731					ath (Check only or	10)		
<u>و</u>	this aldi	은	1 Yes 2 3		Hospital: 1 Inpatie	-	ER/Outpatier 28b. Time o		ner: 4 ☐ Nursing H	lome 5 Resid			ocify)
lon	ding After	ation	1 Natural 2 Accident	5 Pending investigation	(Month, Da	y Yeer)	Injury	Wo	rk? ]Yes 2 □No			,	
<u>X</u>	or Attancatter death Director:	Certification:	3 Suicide 4 Homicide	6 Could not to determined		ury - At hor c. (Specify,	me, farm, sti	reet, factory, office		28f. Location (S City or Tow			ural Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by		29a. Certifier	€ Certifying P	hysician: To the best	of my knov	vledge, deat	h occurred at the ti	me, date and place	, and due to the c	ause(s)	and manner a	s stated.
	To the Ho within 24 h To the Fur completely	edical	(Chack only one)		miner: On the basis o and manner st	f examinati ated.	ion and/or in						
)	To the within 7 to the comple	Σ	29b. Signature enc	title of certifier	1/1	m	M	29c. Licens	se number	29		te signed (Moni	
(			30. Name and add	ress of person who	completed cause of c	death (Item	23a) (Type	Print)	200	0/	MA	Y 3, 20	U4
d	B5		GEORGE I	H. WATHEN	I, MD, 1134	5 PEM	1BROOK	E SQ., #	103, WALD	ORF, MD	2060	03	
	Sta Regist		31. Date filed (Mor	MAY 0 6	2004	ars signal	15 19	parte					

			1 - For State Registrar	State of N	/laryland		artment of <i>tificate of</i>		and M		giene Reg. No 2	004	159	121
	Dhyoia		1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	ath Day	Year	3. Time of	
	Physic /Medi		Betty	Jane Bayne	)					May	16"	2004	4:30	Рм
7	Exami	ner	4a. Facility Name (If not institution		r)		4b. City, Town,		of Death			unty of Death		
			1747 Wycliffe 5. Social Security Number		Age (In yrs. Ia	act hirthday)	Baltin If Under 1 Year		24 Hrs	O Data of Bird		ltimor		
	Funeral Director		216-24-8320	1 M 2 N F	76	Yrs.	Months Days		Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp Cour.	lace (State on try) vland	or Foreign
	D		Usual Residence of Decedent		,,,					000.	, 172	7 1101	утапа	
	arylan show	_	10a. State 10b. County			, Town or Lo						1	0d. Inside Ci	•
	8a-f	octo		imore	Bal.	timore							1 🗌 Yes	2 × No
	with ti	E	10e. Street and Number	_			10f. Zip Code				10g. Citizen	of What Cour	. ,	
	eath	era	1747 Wycliffe	Avenue 12. Was Deceden	t Ever in II 9	2 12 1	21 2		nin? /Can	oifu Vaa aa Na	14	USA Race - Americ		
(0	r Iten	by Funeral Director	1 ☐ Never Married 2 ☑ Marr	Armed Forces	?	3.	Was Decedent of Yes, specify Cut	oan, Mexican	, Puerto F	Rican, etc.)	14.	Black, White,		
03	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	•		I□Yes 2√2No	Specify:			Spe	ecity:	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show ha Mwdical Examinar must be notified at	Completed	15. Deceden (Specify only highe	's Education		16a. Deced	lent's Usual Occu	pation during most	of workin	a	16b. Kind o	of Business/Inc	dustry	
121	vithin ne. han	шb	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of work done OO NOT use retire	∍d)			П	. U===		
2	Hygie Hygie ther t		12 17. Father's Name (First, Middle,	Last)		Homem	aker	18 Mother	r's Name	(First, Middle,		) Home		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic svant, I're Medical Examinar must be notified at	To Be		artin					rquei		edrick			
ary	shoul nd M	1	George 5. Ma  19a. Informant's Name/Relations			19b. Mailin	g Address (Stree						Code)	
ž	and 2 alth a 27 is		Mr. Leonard Bayr	ne, Jr./ Hus	sband		Wycliff						,	
ore	of He of He fiterr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 DRomount from State		ace of Dispo	sition (Name of natory or other pla	ace)	Da	ate	20c. Location	on - City or To	wn, State	
Ē	Pages ment of I ant: If its ury or o		'4 □Donation 5 □ Other (S		Mor	eland	Mem. Par	ck   5	5-20-	-04	Park	ville,	Md.	
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or othar tra <u>once.</u>		21. Signature of Funeral Service	Licensee		22	Name and Addr Ruck 1050	ess of Facility Towson York R	Fune	eral Ho	me, Ir	1204		
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cause only one caus in n each	ed the death.	. Do not ente	er the mode of dy	ing, such as o	cardiac or	respiratory arr	est,		Approximate Interval Bety	e Ween
	Pinysician		Immediate Cause (Final disease or condition	Pul	man	and s	anlo	U					Onset and D	Death
	/Medical Examiner		resulting in death)	Due to lor a	s a conseque	ency yh:	can			-				
	- Xuillilli	<u>_</u>	Sequentially list conditions,	b. Jan	s a conseque	the	can	uno	ma					
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Que to (or a	s a consequi	ence or):						5		
Ć.	execunate and and al-tra	Examine	that initiated events resulting in death) Last	c Due to (or a	s a conseque	ence of):								
8760,	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcall		d										
68	ntifica ng ph as th		IS ESSAAL S			-								
Вох	leath certifica attending pt if for use as the	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcom 1 ☐Live birth			Ectopic pregnanc	v				Date of deliver	-	
O.	the at	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant : 9☐ Unknown	at time of dea		Other (specify) _					Month	Day Y	'ear
Θ.	that the dead by the detached	Ph	Part II. Other significant condition	ns contributing to death	hut not resul	ting in the un	derlying cause an	von in Part I		23a Did tol	22000 1150 0	ontribute to the	o savino of d	noth?
of Vital Records,	uires tha signed Id be det	d by				and an interest	donying dabba gr	voir art uit i.		1 🗆 Ye				nknown
COL	w require been signature	ete								24a. Was a				
Re	The lay	Completed								autops	y	death?	rpletion of ca	luse of
ta		a)	25. Was case referred to medical					26 Place	of Doath	1 ☐ Yes 2 Check only on	No	1 🗆 Yes	2□ No	
<u>&gt;</u>	Physiclan: this certific ral director,	To B	examiner? 1 ☐ Yes 2 XNo	Hospital:	ient 2∏E	R/Outpatient	3□ DOA Ott	oor	sing Hom	/		Other (Specify)	1	
	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Inj		28b. Time of Injury	28c. Inju Wo		-	3d. Describe ho				
Sio	Attending I ar death. actor: After by the funer	atlc	Z ☐ Accident investig	ation	,,	,		Yes 2□N	lo					
Division	of or Attencater death after death Diractor:	Certification;	3 Suicide 6 Could r 4 Homicide determ	ned   288. Place of it	njury - At hom tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28	If. Location (St. City or Town	reet and Nu , State)	mber or Rural	Route Numb	70 <i>r</i> ,
	pital ours a aral C		200 Continu	Phone in the American										
	To the Hospital or Attenwithin 24 hours after deat To the Funaral Diractor: completely filled in by the	fedical	one)	g Physician: To the bes Examiner: On the basis and manner s	or examination	on and/or inv	estigation, in my o	opinion, death	place, an	d at the time, da	ate and plac	e, and due to	the cause(s)	
	To COLT	Σ	29b. Signature and title of certifier	77/		1	29c. Licens	se number	-601	25	9d. Date sig	ned (Month, D	ay, Year)	r
7	$\sigma_{i}$		france	of way	n-a	A).	212	-77	0-1	1	1 0	>//7/	104	
	10		30. Name and address of person	who completed ca f	death (Item 2	23a) pe, F	Print)	-1/2/2	01	#11/1	Hon	11/10	14/2	1092
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	ire	1/1003	10012	raf	11/1/2	VITIET	11/14/	1016	
1	Registr		MAY 1 9 200	14 Secretar	A.	books			/	/				

			1 - For State Registrar	State of Maryla	nd / Dep		lealth and M	lental Hygie	-	15922
			Decedent's Name (First, Middle, La	st)				2. Date of Death	THOS O O CO	3. Time of Death
	Physic		Louis	Be	ond			5 <sup>Month</sup> 17	2004 Year	2:10p M
j	⊸ /Medi Exami		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of Death	
			3333 N. Calvert	Street		Balt	imore		NA	
	Funeral		Social Security Number 6.5	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign
	Director		239-48-9388	MM 2□F 69	Yrs.	Months Days	Hours Min.	4-30-35		intry)
	P.		Usual Residence of Decedent					<del></del>		
	anyla ahov	_	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	8e-1	ctc	Md. NA		Balti	1				M∏Yes 2∏No
	or 2	DE	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
	ath v	ra a	1617 E. 29th Str	·		2123			USA	
	er de Itams	nue	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Funeral Director	1 ☐ Never Married 2√2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ✓ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2X No	Specify:		Specify: Bla	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or itams 23e or 28e-f ahow int, the Medical Exercitive countilled at	D.	15. Decedent's E	Year or Dates:	1 40- D					
15	n 72	Completed	(Specify only highest gra		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of worki	ing 16	ib. Kind of Business/I	ndustry
12	with:	m	Elementary/Secondary (0-12)	College (1-4or 5+)	1 7					
	filed with Hygiene othar tha		12th grade 17. Father's Name (First, Middle, Last,		T.OM	Motor Ope		(First, Middle, Ma	.R. Grace	
an	d be antal cad o	o Be			_					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. If man 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinating the malified at	70	Daniel 19a. Informant's Name/Relationship (	Type, Print)		ng Address (Street	Rosa	E.	Che	rry
S	and 2 salth ar	1	Mildred Bond	Wife	062503550					0 0000)
ō,	tand Health tam 27		20a. Method of Disposition	WIIE 20b.	Place of Dispo	E. 29th esition (Name of matory or other place	Street, L		Md 212 c. Location - City or T	
20	0		1 ■8urial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif			matory or other place Forest V				
Baltimore,			21. Signature of Funeral Service Licer			2. Name and Addres			Owings Mil	
Ba	permit. Departr Importa any inju		Ment	6		March F.H	,	1101 E.	imore, Md North Ave	. 21202
			23a Part1. Enter the disease, or com	plications that caused the dea						Approximate
. 18			23a Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1		, ,			Interval Between Onset and D
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	7) W	E436	J 2021	Conce		month
	Examiner	ш			quonus orj.					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):					
7	uted d ansit	E	Cause. Emer Underlying Cause (Disease or injury that initiated events							
03	be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a consec	quence of):					
19	tte be tysicia ne bui	cal		. d						
68	tifica g ph as th									
Вох	death certifica e attending ph d for use as th	N/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		7E			23d. Date of delive	ery
	deatle atte	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	at the de by the a tached	hys	9 Unknown	9□ Unknown						
S,	The law requires that the tee bas been signed by the bage 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ğ	w require been sig should b							1 🗌 Yes	No 3□ Prob	ably 4 🗆 Unknown
S	aw requ s been 2 shoul	plet						24a. Was an	24b. Were auto	psy findings available
Vital Record	The lav	Completed						autopsy performed 1 ☐ Yes	prior to co	mpletion of cause of
ta		0	25. Was case referred to medical				26. Place of Death		No 1 ☐ Yes	2   NO
	N S D	OB	examiner? 1 ☐ Yes 2 <del>☐ No</del>	Hospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Othe	r	ne 5 Residence	e 6 Other (Specif	mitrates
l of	g Ph ler th heral	2	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	at 2		njury occurred	
Division	를 는 축 호	ertification:	2 Accident 5 Pending investigation		Injury	Work M 1 □ Y	es 2 No			10 (2
Vis	ar de	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	eet, factory, office	2	8f. Location (Stree	t and Number or Rura	l Route Number,
ō	s afte	Cer	· ·	building, stc. (opecin	777			City or Town, S	(ate)	
	Hospital		29a. Certifier 12 Certifying Ph	ysician: To the best of my kno	owledge, death	occurred at the time	e, date and place, a	nd due to the cause	e(s) and manner as s	ated.
	To tha Hospital or Attan within 24 hours after deatl To tha Funaral Director: completely filled in by the	Medical	one)	niner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	inion, death occurre	d at the time, date	and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)
•	+		(15)	MO		104	4947	m	my 18th	2004
	101		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type)	Print)	7 -		1	1
	(e		smley Wall	EEEE (27	Nost	5 Glu	Whe	IJ By	more /	4JakB
	Sta		31. Date filed (Morlfn, Day, Year)  MAY 1 9	32. Registrar's Signat	ature	1				
	Registi	aı	min: 1 2	LUUT FARMEN	1 15	SPORCE!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Přívsician Year 12:48 PM Anthony May 2004 /Medical Randolstown

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day,

06 08 4a. Fecility Name (If not institution, give street and number) Examiner 4c. County of Death Northwest Hospital Center 5. Social Security Number Birthplace (State or Foreign Country)
 AL 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F Yrs. Director 55 214-54-2806 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director FLBroward Miramar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33027 U.S.A. 2756 S.W. 139th Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or tlea any filed yor other traumatic event, I'm Medical Estring any inlury or other traumatic event, I'm Medical Estring 1 ☐ Never Married 2 X Married 1 ☐ Yes XXNo þ Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Information Security Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 12yrs IBM Computers Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Roy Bates Leslie Tatum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elena Bates-Wife 2756 S.W. 139th Ave, Miramar, FL 33027 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 5/21/04 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Md 21. Signature of Funeral Service Licensee 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple organ system tailure /Medical Due to (or as a consequence of): Examiner Systemic inflammator Sequentially list conditions, if an , leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last heratic attending physician for use as the burial Division of Vital Records, P.O. Box 68760 >5months henatitis C disease Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Type I diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic anemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 V No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Thomicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

7)0

DHMH 17 Rev 1/2001

State Registrar

MAY 1 9 2004

31. Date filed (Month, Day, Year)

Boston

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)
Northwest Hospital Center

Sports

D28462

May 15, 2004

Randallstown, Maryland 21133

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 15924 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** May 5:00 P M 2004 Patricia JoAnn Bosnick /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 2502 Braddock Road Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 25, 19 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF 215-34-0265 67 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Carrol1 Mt. Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21771 U.S.A. or Itema 23a 2502 Braddock Road death \ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "naturel", or Item any injury or other traumatic avent, Item Medical and Once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data/Information Owner/Manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Adeline Knight 2 James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul Z. Bosnick/Husband 2502 Braddock Road, Mt. Airy, Maryland, 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 ☑Other (Specify) Entombment Mt. Olivet Cemetery | May 10, 2004 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physicier Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Records, þ page 2 should be 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 ☐ No 1 Yes 1 🗆 Yes Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 1 🗌 Inpatient sesidence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA funeral dir of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No s after death. 2 Accident investigation the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Exampler: On the basis of examination and/or investigation, in my opinion, death accurred at the cause(s) and manner as stated 29a. Certifier the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signature and ddress of perso h who completed gause of death (Item 23a) (Type, Print) 30. Name at h dethis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 9 2004

			1 - For State Registrar	State of M	laryland	•		nt of Ho te of D		nd Me		jiene <sub>eg. No.</sub> 2	004		925
	Physici	an	Decedent's Name (First, Middle, La	ast)						1	<ol><li>Date of Dea Month</li></ol>	th Day	Yeer	3. Time o	of Death
	/Medic		ROBERT	HARVEY		BRADS	Г				May	13,	2004	8:45	Р
1	Examir	ıer	4a. Fecility Name (If not institution, gi		")		4b. Cit		Location of			4c. Cou	inty of Deeth		
			5111 Old Auger F 5. Social Security Number 6.		ge (In yrs. I	ast hirthday)	If Und	er 1 Year	isfie If Under 2		Date of Birth		Some	rset place (State	or Foreign
	Funeral Director			1⊠M 2□F	73		Month		Hours	Min.	B. Date of Birth (Month, Day Dril 2.	Year) 1, 193	Cour	land	or r or orgin
1000			217-36-2020 Usuel Residence of Decedent												
	ylanc how		10a, State 10b. County		10c. City	, Town or Lo	ocation						1	Od. Inside C	
	B Ma	ctor	Maryland Some	rset				Cr	risfie	eld				1 U Yes	s 2⊠No
	hours after death with the Maryland tural, or flems 23a or 28a-f ehow al Exertires must be rotified at	Director	10e. Street and Number				10f. Z	ip Code			1	l0g. Citizen	of What Cour	itry?	
	23a		5111 Old Auger F						2181				USA		
	tems	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Dec If Yes, sp	edent of His ecify Cubar	spanic Origi n, Mexican,	in? (Spec Puerto R	ity Yes or No- ican, etc.)		Race - Americ Black, White,		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates			1 🗆 Yes	2 🛛 No	Specify:			Spe	city: Whi	.te	
21215-0036	n 72 hours after death with the Marylan "natural", or items 23a or 28a-f ehow kolical Examinat must be trotified at	ed t	15. Decedent's E		: 195	16a, Dece	dent's Us	ual Occupa	tion			16b. Kind of	f Business/In	dustry	
15	in 72 n "nat	Completed	(Specify only highest gi		. 5 . \	(Give	kind of v	rork done d use retired)	urina most i	of working	7			,	
212	d within giene. ir than "	Eo	12	1	3+)	1	Mort:	cian				F	`uneral		
b	be filed tal Hygi d other event, II	Bec	17. Father's Name (First, Middle, Las	t)					18. Mother	's Name (	First, Middle,	Maiden Surr	name)		
<u> a</u>		10	H. Harvey Br	adshaw					Kathl	Leen	Unglauk	0	,		
Maryland	and and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addre	ss (Street a	nd Number	or Rural	Route Number	r, City or Tov	wn, State, Zip	Code)	
	s 1 and f Health item 27 other tr		Betty J. Bradsha	w (Wife)	20h B	5111 lace of Dispo			Road	1 - C	risfie				.7
ore			20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	☐Removal from Stat		emetery, cre	matory of	ame or other place	) <u> </u>	Da	ile.	20c. Locatio	on - City or To	wn, State	
턡	tmen tant:		*4 □Donation 5 □ Other (Spec		Sunny	yridge M					, 2004		ield, l	Maryla	and
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lice	LOUGONO							eral Ho				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	aDue to (or a	ed the death	n. Do not en	ter the m	ode of dying	, such as c	ardiac or	- Crisf respiratory arr	est,	Mary	Approxima Interval Be Onset and	ate etween d Death
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequ										
.O. Box 6	at the death certific by the attending p tached for use as t	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic ⊒ Other (	pregnancy specify)					Date of delive Month	ery Day	Year
rds, P	w requires that been signed t should be det	b	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	ınderlying	cause give	n in Part I.		23e. Did to	bacco use c es 2 □ No	ontribute to the	he cause of bably 4	
Il Records,		Completed							-		24a. Was a autops perform	sy	death?	psy findings mpletion of 2 No	s available cause of
Vital	sician: The certificate rector, pay	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only or	re)			
of	ding Phys	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of In (Month, E	jury	ER/Outpatre 28b. Time o Injury		28c. Injury Work	4 🗆 14013		e 5 Reside		Other (Specificurred	r)	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	njury - At ho etc. (Specify	me, farm, st					3f. Location (S City or Town		ımber or Rura	il Route Nur	mber.
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical C		Physician: To the best eminer: On the basis and manner	of examinat										(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			, , , , , , ,	2	9c. License	number		2	9d. Date sig	gned (Month,	Day, Year)	
	7		1/lla	MD				D-39	813			May .	17, 20	04.	
	20		30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)								
_	V		Mike Atkins, M.				у –	Crisf	ield,	Mary	yland 2	1817			
149	St Regist	ate rar	31. Date file MAY 1 Day Year 2004	Server Server	trar's Signa	turg	door	las							

	_		1 - For State Registrar		Maryla		artment of rtificate of			R	eg. No. 20	04 15926
	Physic /Medi Exami	cal	Denald C Brady      A. Facility Name (If not institution, gives Saint Joseph	e street and numi		dr eavo	4b. City, Town,		f Death	2. Date of Deat Month	Day  14 29  4c. County	
	Funeral Director		Social Security Number 6. S	ex 7		s. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 2	Min.	Date of Birth (Month, Day, January 2	Year)	altimore  9. Birthplace (State or Foreign Country)  Baltimore, Maryland
	the Maryland 28e-f show	Director	10a. State 10b. County  Maryland Baltimore  10e. Street and Number			city, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
36	filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or items 23a or 28e-f show ont, the Madical Examinar must be notified at	Funeral	2954 Manns Avenue  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Forc 1 [X]Yes 2 If Yes, Give Year or Dat	es? □No		Vas Decedent of If Yes, specify Cul		in? (Specif , Puerto Ric			- American Indian, c, White, etc.
Maryland 21215-0036	be filed within 72 hours ntal Hygiene. sd other then "neturel", event, I're Madical Ex-	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation		16a. Deced	dent's Usual Occu kind of work done DO NOT use retin	during most ad)		I	16b. Kind of Bus	siness/Industry
arylanc	should be ind Mental marked c	To Be	17. Father's Name (First, Middle, Last)  John F. Brady  19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	ng Address (Stree	Ada Ma	y Biss	el	faiden Surname	
Baltimore, M	s 1 an of Heal item 2	5	Robert Brady (Son)  20a. Method of Disposition  1 Description 3 Community 4 Donation 5 Other (Specification)			Place of Dispo cemetery, cren	enns Avenu sition (Name of natory or other pla emetery Mar	e Balt	imore,	Marylan	d 21234	City or Town, State
Balt	permit. Page Department of Importent: If any injury or		21. Sport re of Funeral Service Licen  23a. Part Leithe disease, or company and the disease, or company and the disease, or company and the disease.	o Opero	cki	//	Name and Addr Assahn Fun 101 Belair	Road Ba	ltimor	e,Marvla	nd 21236	
8760,	American and hypoxican and the burial-transit the burial-transit	Ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPTI Due to (or b. URINA Due to (or	as a conse	quence of):	NFECTIO					Approximate Interval Batween Onset and Death
P.O. Box 68	death certifi e attending id for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	t 2 ☐ Fei tat time of	al déath 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date Monti	= -
Ś	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions of ISCHEMIC BOWEL	ontributing to deat	h but not re	sulting in the un	derlying cause gr	ven in Part I.		23e. Did toba	√/	oute to the cause of death?
Vital Record	The law ate has b	e Completed	25. Was case referred to medical					00 81	-		prie dea No 1 [	ere autopsy findings available or to completion of cause of ath? I Yes 2 No
Division of Vi	ending Physicien: aath. or: After this certifice he funeral director, i	atlon; To B	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inp. 28a. Date of I (Month,		ER/Outpatient 28b. Time of Injury	28c. Inju	ner: 4□ Nurs	ing Home		ce 6 Other	
DIVIS	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Il Certification;	3 Suicide 6 Could not be determined	building,	etc. (Spec	(ty)	et, factory, office			City or Town,	State)	or Rural Route Number,
)	To the Hos within 24 hd To the Fun completely	Medical		iner: On the basis	or examin	ation and/or inve	29c. Licens	pinion, death	piace, and occurred a	it the time, dat	e and place, and	ner as stated. d due to the cause(s)  Month, Day, Year)
	Sta Registr	te	30. Name and address of person who compared to the second	32. Regi	death (Ite	CLED T		TOWSO	N <sub>7</sub> Mi	<del>aryLa</del>		<u> </u>

			1 - For State Registrar	te of Maryland / Depa	artment of I	lealth and M Death	ental Hygie	ene 2004	15927
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Albert L. Blumbe     4a. Facility Name (If not institution, give street a		-	or Location of Death	2. Date of Death Month May 1	Day Year 5, 2004	
	Funeral Director		5. Social Security Number 215-40-3744  Usual Residence of Decedent	7. Age (In yrs. last birthday)	Bel If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y June 11,	Harford (ear) 9. Birth Con 1943 Mari	d pplace (State or Foreign intry) YLand
	r 28e-f show	irector	10a. State 10b. County  Maryland Harford  10e. Street and Number	10c. City, Town or Lo	Air 10f. Zip Code		100	. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?
336	be filed within 72 hours after death with the Maryland nia! Hygiene. od other then "neturel", or Items 23a or 28e-f show event, the Madical Examination in at the modified at	by Funeral Director	1 Never Married 2 Married 1 If Y	Yes 2 X No	Vas Decedent of lift Yes, specify Cub	21014 dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	U.S.A.  14. Race - Amer Black, White Specify:	
Baltimore, Maryland 21215-0036	e filed within 72 hor al Hygiene. I other then "neture vent, the Madical E	Completed	15. Decedent's Education (Specify only highest grade comp.  Elementary/Secondary (0-12) Co  17. Father's Name (First, Middle, Last)	lege (1-4or5+) (Give life. L	ent's Usual Occup kind of work done OO NOT use retire WIANCE A	during most of workir d) gent	S I	elf-Employ	
laryland	2 should be f and Mental h is marked of eumetic ever	To Be	Samuel Blumberg  19a. Informant's Name/Relationship (Type, Pri		g Address (Street	18. Mother's Name Sarah and Number or Rural	Diamon	d	p Code)
imore, N	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke eny injury or other treumetic once.		Mrs. Connie Blumberg  20a. Method of Disposition  1  Burial 2  Cremation 3 Remova  4 Donation 5 Other (Specify) Ent	20b. Place of Disposicementery, cremombrent: Parkwood	sition (Name of patory or other place Mausole	um 5/18/	2004 B	1014 c. Location - City or T altimore.	Maruland
Ball	Dermit Depart Import eny in		21. Signature of Funeral Service Licensee  Ducin Ce Uvel  23a. Part1. Enter the disease, or complications	that caused the death. Do not ente	Name and Addre Chumunek O W. Maci or the mode of dyir	ss of Facility Funeral H Phail Rd.,	ome of B Bel Air	el Air. Iv , MD 21014	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	ue to (or as a consequence of):		ertic C.			Interval Between Onset and Death
8760,	cate be executed obysician and the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequence of):					
P.O. Box 68	ath certific	Physician/Medi	in the past 12 months?		Ectopic pregnancy Other (specify)	,		23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contribution	g to death but not resulting in the un	derlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
Vital Records,	icien: The law certificate has b rector, page 2 sh	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available impletion of cause of
Division of V	Attending Physr death. sctor: After this by the funeral directions	ertification; To B	Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ ER/Outpatient Date of Injury (Month, Day Year)  Place of Injury - At home, farm, stre building, etc. (Specify)	28c. Injun Worl M 1 🗆	er: 4 Nursing Hom y at 28 k? Yes 2 No	e 5 💢 Residence 3d. Describe how i	t and Number or Rura	
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in Inc.	Medical C	(Check only 2 Medicel Examiner: On	To the best of my knowledge, death the basis of examination and/or inve manner stated.	estigation, in my o <sub>l</sub>	pinion, death occurred	d at the time, date	and place, and due to	the cause(s)
•	75		30. Name and address of person who completed	d cause of death (Item 23a) (Type, P	) 333 (rint)	551	Sr,	101 17,0	2004
	Sta Registra		31. Date filed (Month, Day, Year)  MAY 1 9 2004	d cause of death (Item 23a) (Type, P 110 Philipse (Phix 32. Registrar's Signature	sould	17 130	(TIME	el 2 C	7

		1 - State Registrar AME	ND ITEM #	5 pertatin essi 1 PER PHY C83	1 5/26/0	04 Ce	tificate d	of Dea	th		Reg. No. 2	004	1592
Physic	ian	Decedent's Name	(First, Middle, L	.ast)						<ol><li>Date of De Month</li></ol>	ath Day	Yeer	3. Time of Death
/Medi		<del>Leila</del>	Ann B		LELIA I	RKOWN				Мау		2004	4:30 A M
Exami	ner	-	-	ive street and number, tric & Reho		ation	4b. City, Tow	m, or Local timor			4c. Cou	inty of Deeth Balt	imara
Funera		5 Special Society			ge (in yrs. ias		If Under 1 Y	ear If Un	der 24 Hrs.	8. Date of Bir	th		lece (State or Foreig
Funeral Director		214-74-7	444	1□M 2□XF	72	Yrs.	Months Da	ays Hou	ırs Min.	March .	3, Year 193	2 Penn	sylvania
>===		Usual Residence of 10a. State	Decedent 10b, County		10c City	Town or Lo	eation					1	0d. Inside City Limit
sho a la la	5			~ h 0	Too. City,		Baltimo	140					1 ☐ Yes 2 ☑ N
28a-	ect	Maryland	Baltimo	one	1	-	10f. Zip Coo				10g. Cilizen	of Whal Cour	
3a or	0		arborn 1	Drive				2123	6			u.s.A.	,
ms 2	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	. 13.	Was Decedent f Yes, specify (	of Hispanic	Origin? (Spec	cify Yes or No	)- 14. F	Race - Americ	
penint. Tages I and 2 strong between which 2 from a green occur with the manyane Department of Health and Mential Hygiene.  Misporant: If ten 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu		ed 2 Married	I ∏Yes 2.2X If Yes, Give	No		1 ☐ Yes 2 🛣			noari, etc.,			
tural al Ex	q pa	3 Widowed	15. Decedent's	Year or Dates:		16a Decer	dent's Usual O	cupation			16h Kind o	f Business/Ind	
Aedic	Completed		ify only highest g	rade completed)		(Give	kind of work do	one durina i	most of workin	g	TOD. KING O	. 00311103371110	Justry
Hygiene. other then ont, the Mes	mo	12th Gra		College (1-4or	5+)	Lab	Assist	ant			Manu	factur	ing
d other	Be (	17. Father's Name (						18. M	lother's Name			name)	
marked o	10	Lester							Helen				
h and 7 Is ma		Ms. Caro		(Type, Print) (Executi			Box 26		_				
Health tem 27		20a. Method of Disc		Lxecui	20b. Plac	ce of Dispo	sition (Name o	f	my r	ate		on - City or To	
nent of int: If it		1 🗆 Burial 2		Removal from State	cen	netery, crer	natory or other Cremato	place)	5/19/0	14		•	laryland
Department Important: I any injury o		21. Signature of Fu			bug		. Name and A	_					
Departr Importa any inju		1	61	16			9705 Be						
*		23a. Part1. Enter the	ne disease, or co	mplications that cause by one cause on each	d the death. ine.	Do not ent	er the mode of	dying, such	as cardiac or	respiratory a	rrest,		Approximate Interval Between
hysician		Immediate Cause ( disease or conditio	Final	C	2 MM	atr	y to	zuln				5	Onset and Death
/Medical		resulting in death)		Due to (or as	a conseque	nce of):	( 0-	0	0				
xaminer	_	Sequentially list cor	nditions.	ьС	yed 1	uch	re 8	leg	2 9	serve			
ısit	nine	f any, leading to im- cause. Enter Unde Cause (Disease or that initiated events	mediate rlying injury	Due to (or as	a conseque	nice oi):	do	an I	_				
al-tran	Examiner	that initiated events resulting in death) L	.ast	c. Due to (or as	a conseque	nce of):		4 444	1				
physician and s the burial-transit	dical			d.	Chry	se ho	S	Her	V4- 1	Farly	re		
					7	)					1	Ì	
attending pt	by Physician/M	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1 ☐ Live birth			Ectopic pregn	ancy				Date of delive	,
ate has been signed by the attending page 2 should be detached for use a	sick	in the past 12		4☐Pregnant a 9☐ Unknown			Other (specif)					Month	Day Year
signed by the a	Phy	9 Unknown	icant conditions	contributing to death I	but not regulti	ing in the w	adarhina caus	anyon in D	201	23a Did to	obacco use c	ontribute to th	e cause of death?
signe	l by	rath. Other signif	Dr. a.b.	elt m	olla	A-	idenying cause	giv <del>a</del> it iii F	aiti.				ably 4 Unknov
been si should	Completed	1	0	4.0	-l	1	. (		<del> </del>	24a. Was			
s has	du		- 8 Cov	Mu	my	m				autop	rmed2-	prior to cor death?	osy findings availab npletion of cause o
ificate or. pa	e C	25. Was case refer	red to medical					ne D	lace of Death		2 No	1 🗆 Yes	2□ No
r this certificaral director.	To B	examiner?	_	Hospital:	ent 2 EF	R/Outpatien	t 3 DOA		Nursing Hom			Other /Specifu	·)
		27. Manner of Deatl		28a. Date of Inj.	ury 2	8b. Time of		Injury at Work?		8d. Describe h			/
ter thi		1 ☐ Malural 2 ☐ Accident	5 Pending investigati	ion	, , , , ,	,ury		1 Yes 2	2 🗆 No				
sath. or: After thi	atio			286. Place of in	jury - Al hom tc. (Specify)	e, farm, str	et, factory, off	ice	2	8f. Location (S City or Tox	Street and Nu vn. State)	mber or Rura	l Route Number,
ter death. irector: After thi by the funeral of	tificatio	3 Suicide 4 Homicide	6 Could not determine	building, e									
urs after death. rel Director: After thi lled in by the funeral	Certification;	3 Suicide 4 Homicide	determine	bullaing, e									
24 hours after death. Funerel Director: After thi		3 Suicide 4 Homicide  29a. Certifier (Check only	determine	Physician: To the best eminer: On the basis of	of examinatio	edge, death	occurred at the	ne time, date	e and place, as death occurre	nd due to the d	cause(s) and date and plac	manner as st	ated. the cause(s)
ithin 24 hours after death.  o the Funerel Director: After thin  ompletely filled in by the funeral of	Medical Certificatio	3 Suicide 4 Homicide	determine	Physician: To the best	of examinatio	edge, death n and/or inv	estigation, in r	ne time, date ny opinion, cense numb	death occurre	d at the time,	date and plac	manner as stee, and due to	the cause(s)
the s		3 Suicide 4 Homicide  29a. Certifier (Check only one)	determine	Physician: To the best eminer: On the basis of	of examinatio	edge, death	estigation, in r	ny opinion, cense numb	death occurre per	d at the time,	date and plac	e, and due to	the cause(s)
within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral of		3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and	determine	Physician: To the best eminer: On the basis and manner s	of examination tated.	n and/or in	29c. Lic	ny opinion, cense numb	death occurre	d at the time,	29d. Date sig	ned (Month, I	the cause(s)  Day, Year)
within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral to		3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and	determine	Physician: To the best eminer: On the basis of	of examination tated.	i (Type,	29c. Lic	ny opinion, cense numb	death occurre	d at the time,	29d. Date sig	ned (Month, I	the cause(s)

DHMH 17 Rev 1/2001

Wayne A. Bidinger 04-3343 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	004	13925	
	Physic	an	Decedent's Name (First, Middle, Last     Wayne A.	Bidinger				2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medi		4a. Fecility Name (If not institution, give			4h City Town o	r Location of Death	May 1		)4 ounty of Death	7:30 P M	
	Examir	ner	6609 Tallulah Ave			Woodlav				Ltimore	County	
	Funeral Director		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bird (Month, Da July 1	th	9. Birthp	lace (State or Foreign	
	P.		Usual Residence of Decedent									
	arytar show	_	10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits	
	Ba-f s	cto	Md. Baltimore Woodlawn								1 ☐ Yes 2 🛣 No	
	th with the	ai Director							10g. Citizen of What Country? U.S.A.			
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be multiled at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ Who If Yes, Give Year or Dates:  Joation 16a. December 16a.		3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:			1	14. Race - American Indian, Black, White, etc. Specify: White		
2-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad			dent's Usual Occup	pation		16b. Kind of Business/Industry			
2	within 9	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		ive kind of work done during most of working. DO NOT use retired) Driver		9	т		~	
land 212	e filed within al Hygiene. other then vent, the We	S	9			Liver				urance	Co.	
	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name					
Z	2 should be and Mental Is marked (	2	Albert Bidi	O .				~	aret Paulus			
Var	12 sh h and r Is m		19a. Informant's Name/Relationship (Ty Maynard Paulus		1.5	-	and Number or Rural				Code)	
	1 and 2 Health tem 27 I		20a. Method of Disposition	- ouere			Ave., Bal	_			- 21	
mor	Pages nent of H ant: If ite ury or of	20a. Method of Disposition  1										
Balt	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Licens	Call	2	2. Name and Addre Eckhar	ss of Facility dt Funeral	Chape	1, P.	A. Mil	21117	
	- 1		Eckhardt Funeral Chapel, P.A.  11605 Reisterstown Rd., Owings Mills, Md.  23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between									
}	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Hyperto		enosden	The card	wasi	Mard	neone	Interval Between Onset and Death	
		iner	Sequentially list conditions, if any, loading to annicodate cause. Enter Underlying Cause (Disease or injury	Otto to (or as a	consequence of):							
90,	certificate be executed iding physician and ise as the burial-transit	i Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):								
87	physi the t	/Medicai		d					_			
Вох		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d.	. Date of deliver Month	ry Day Year	
Δ,	s that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							contribute to the	e cause of death?	
ords	w requires been sig should be							1 □ Y	es 2 💢 N	o 3 🗆 Proba	ably 4 Unknown	
Recc	ysicien: The law r is certilicate has be director, page 2 sh	Completed						24a. Was a autop perfor 1 XYes	sy med?	prior to con death?	osy findings available appletion of cause of	
Division of Vital Records, P.O. Box 68760, Buttimore, Maryland 2121		Be C	25. Was case referred to medical				26. Place of Death (			102103	20.140	
>	Physicien: this certific ral director,	To	examiner? 1 X Yes 2 ☐ No	lospital: 1 🗆 Inpatient	2 ER/Outpatier	t 3 DOA Oth	er: 4 Nursing Home	5 Resid	ence 6X	Other (Specify	At scene	
o uoi	Attending Ph r death. ector: After th by the funeral		27. Manner of Death 1. □ Natural 5 □ Pending 2. □ Accident investigation	28a. Date of Injury (Month, Day )	(ear) 28b. Time o	Worl	yat 28 k? Yes 2 □ No	d. Describe h				
Divis	after deatl	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	28	f. Location (S City or Tow		umber or Rural	Route Number,			
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 ☐ Certifying Physical Check only one) 1 ☐ Certifying Physical Examination (Check only one)	sician: To the best of a ner: On the basis of ea and manner state	kamination and/or in	n occurred at the time restigation, in my of	ne, date and place, an pinion, death occurred	d due to the c at the time, d	ause(s) and late and pla	i manner as sta ce, and due to	ated. the cause(s)	
	within 2 To the Complet	Me	29b. Signature and title of certifier			29c. License	e number	2	29d. Date sig	gned (Month, D	Pay, Year)	
)	. ,,,,,		Jaska Al.	heesberg	MO	0.0	C.M.E.		May 1	L8, 200	4	

Registrar

31. Date filed (Month, Day, Year) MAY 1 9 2004 34 Registrar's Signature

30. Name and address of person who completed cause of \*\*ath (Item 23a) (Type, Print)

Tasha Z Greenberg M.D

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of Maryland /	Depa		Health ar		•	ne 20 (	04 15930	
	Physici /Medio Examir	al ·	Decedent's Name (First, Middle, Last)     HOUSTON J.  4a. Facility Name (If not institution, give street)	et and number)	SR.	4b. City, Town,	or Location of I	1	Date of Death Month	Day Ye	ar J. 57 A M	
	Funeral Director		STELLA MARIS         HOSP           5. Social Security Number         6. Sex           214-50-5846         ¹	CE AT MERCY  7. Age (In yrs. last be provided to the provided	birthday) _ Yrs.	BALTI If Under 1 Yea Months Days	r   If Under 24	Min. (	Date of Birth Month, Day, Ye ec. 13		Birthplace (State or Foreign Country) [aryland	
	death with the Maryland ims 23a or 28a-f ahow f.: ust be nutified at	Funeral Director	10a. State 10b. County 10b. County 10c. Street and Number 1269 Riverside Ave 11. Marital Status 126.		timo	re 10f. Zip Code 212		22/50		Citizen of Wha	•	
0500-0	filed within 72 hours after death w Hygiene. ther than "natural", or Items 23a ther, Ite Modical Expedited: ust I	by	1 🏋 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give A Year or Dates:	a. Decede	Vas Decedent of Yes, specify Cu ☐ Yes 2 ☑ No ent's Usual Occu	Specify:					
ana 21215	s 1 and 2 should be filed within 72 hours after de f Health and Mental Hygiene. Itsm 27 is marked other than "natural", or Items other traumatic event, Ite Mcdical Expolaration	3e Completed	(Specify only highest grade of Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give k life. D	cind of work done O NOT use retire	o during most of ed)			Resident	,	
narylar	2 should be and Mental Is marked raumatic ev	To B	Clarence A.  19a. Informant's Name/Relationship (Type,			Address (Stree	t and Number o		ite Number, Cit			
nore, s	permit. Pages 1 and Department of Health Important: If itsm 27 any injury or other to once.		John A. Creighton  20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)	20b. Place camet	of Dispos ery, crem	Riversi ition (Name of atory or other pla en Mem.	ace)	Date 5/20 2	20c.	Location - City	or Town, State	
Dallillo	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee  22. Part I. Enter the disease, or complicate the property of the pr	40	22.	Name and Addr McCul	ess of Facility 1v-Po1v	niak	Funeral	Home F	nie, Md. P.A. 21230	
	Inysician /Medical Examiner		23a. Part1. Enter 16 disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ions that caused the death. Do ause on each line.  Due to (or as a consequence	ne	r the mode of dy	ng, such as car	rdiac or resp	piratory arrest,		Approximate Interval Between Onset and Death	
,0070	one hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
O. DOA O.	res that the death certifica igned by the attending pt be detached for use as th	Physician/Med	in the past 12 months?	If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		Ectopic pregnanc Other (specify)	у			23d. Date of Month	delivery Day Year	
650	w requires that been signed by should be deta	by	Part II. Dther significant conditions contrib	uting to death but not resulting	in the unc	derlying cause gr	ven in Part I.	2	3e. Did tobacc		e to the cause of death? Probably 4 □Unknown	
ומו וופר	Physician: The law this certificate has braid director, page 2 st	e Completed	25. Was case referred to medical				26. Place of	1	4a. Was an autopsy performed?  Yes 221	prior t death	autopsy findings available to completion of cause of ? es 2 No	
10 11015	tending Physici Jeath. tor: After this cer the funeral direc	Certification; To B	2 Accident investigation	8a. Date of Injury (Month, Day Year)	Time of Injury	28c. Inju Wo M 1	ner: 4 ☐ Nursir	ng Home 5	5 Residence Describe how in			
5	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined 2  29a. Certifier 17 Certifying Physicia	8e. Place of Injury - At home, f building, etc. (Specify)  In: To the best of my knowledg	e. death	occurred at the ti	me, date and pl	lace and di	ity or Town, Sta	(c) and manner	Rural Route Number,	
;	to the Ho within 24 To the Fu	Medical	(Check only 2 Medical Examiner: one)  29b. Signature and title of certifier	On the basis of examination a and manner stated.	nd/or inve	29c. Licens	opinion, death o	occurred at t	he time, date a	nd place, and d	ue to the cause(s)	
	Ø		39. Name and address of person who complete	eted cause of death (Item 23a)	(Type, Pr		0854 B	14:00		7/17/ n el	21202	
	Stat Registra		31. Date filed (Month, Day, Year) MAY 1 9 2004	32. Registrar's Signature	A	park	· M	MAN	200 1	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	21202	

			1 - For Amend Item #29c Registrar	State of M per dvr G	4arylano 31°5/19	/O4 tas	artmen Hificate	t of H e of L	ealth a Death	ind Me	ental H	ygiene Reg. No	200	4 1	5931
i	Physici	an	Decedent's Name (First, Middle, Las	1)	01	6.1					2. Date of D Month	eath Da	y Yea	ar	ne of Death
>	/Media	cal	4a. Facility Name (If not institution, give	street and number	0/	y	4h City	Town or	Location o	f Doath	may	18	County of D		1:13/AM
	Examin	ier	Good Samari	tan 1	40501	Lal	2	al	Gina	210		40	. County of D	eatn	
	Funeral		5. Social Security Number 6. Se		ige (Irryrs. la	st birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. 8	B. Date of B	irth	9. 8	Birthplace (St	ate or Foreign
Č4	Director		214-98-0109	⊒м 2XОF	35	Yrs.	WOULTS	Days	Hours	Φ.	3 04	1 6	9	MD (Country)	
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Insid	le City Limits
	Many First	ţo	MD NA		Bal	Ltimo	re							1 🔯	Yes 2 ☐ No
	or 284	Director	10e. Street and Number		1 20.		10f. Zip	Code				10g. Ci	izen of What	Country?	
	ath w		2303 Terra Firm	na Road				212	25				U.S.	Α.	
	filed within 72 hours after death with the Maryland Hygiene. Hysiene. Hygiene Table 1. or tems 23a or 28a-f show ent, I've Medical Examiner must be mailing at	by Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	. 13. \	Was Deced f Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican,	in? (Spec , Puerto Ri	ify Yes or N can, etc.)	0-	14. Race - Al Black, W	merican India hite, etc.	n,
920	urs aft	by F	XXNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 [X If Yes, Give Year or Dates:	-		1□Yes 2	X No	Specify:			-	Specify:	Black	
21215-0036	72 hou	ted	15. Decedent's Edi (Specify only highest grad			16a. Deced	lent's Usua	Occupa	tion	-		16b. K	ind of Busine		
2	ithin re.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	kind of wor. DO NOT us	e retired)	uring most	or working	7				
2	iled w Hygier ther th		12th grade  17. Father's Name (First, Middle, Last)	na		Nur	se A		40 11-15				sing	ноте	
	2 should be filed within and Mental Hygiene. Is marked other than Bumatic event, the Ma	Be c	Robert Clay						Phyl.		First, Middle Doso	e, Maiden	Sumame)		
ary I	should ind Men marke umatic	To	19a. Informant's Name/Relationship (T)	/pe, Print)		19b. Mailin	g Address					ber. City o	r Town, State	Zin Code)	-
	127 g d		Phyllis Braswel	.l-Mothe	er								imore		21225
ore	0 0 = =		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State		ce of Disponetery, cren	sition (Nam	e of her place	)	Dat	te	20c. Lo	ocation - City	or Town, State	9
timore,	t. Pages tment of t tant: If it		`4 ☐Donation 5 ☐ Other (Specify)			ıtus	Memo	ria:	l Par	rk 5	/22/0	)4 A	rbutu	s, Md	
Ba	permit. Pag Department Important: I any injury c once.		21. Signature of Funeral Service Licens	60		Ma	. Name and	F/H	West	t	_				_
B.			23a. Part1. Enter the disease, or comp	lications that cause	ed the death						Balt:		e Md	2121 Approxi	
	Pnysician	. 1	Immediate Cause (Final	ne cause on each	line.			, or cyling	, 50011 43 0	ardiac or i	ospiratory (	211651,		Interval	Between and Death
	/Medical		disease or condition resulting in death)	a. ue to (or as	s a conseque	nce of):								Two	week
	Examiner	Ш	Sequentially list conditions	Huma	n in	zmie	nodi	chic	iene	. Vi	nis	inte	retion	Tun	years
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseque	nce of):	5 Tree 500	/	/	/	101110000	1			1
1	xecut and al-tran	Examine	that initiated events resulting in death) Last	c. Due to (or as	s a conseque	nce of):							-	-	
(g)	ate be executed hysician and the burial-transit	dical E		4											
		ledic	XX	J											
Вох	death certific e attending p	an/N	200. Was decedent pregnant	23c. If yes, outcome 1□Live birth	e of pregnance		Ectopic pre	anancy					23d. Date of d	elivery	
о П	0 0	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐ Pregnant a 9☐ Unknown			Other (spe						Month	Day	Year
J.	that the sed by detacl		Part II. Other significant conditions co	ntributing to death t	but not resulti	ng in the un	derking on	usa awas	in Bort I		22a Did	tobassa	se contribute	to the sauce	of double
Hecords,	law requires that the as been signed by th 2 should be detache	d by			21.1101.100011	- ig iii alo uli	derlying oa	aso givei	INIFARLI.		_	Yes 2[	_		Unknown
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ř	0 5 0	Completed									auto perfe	psy ormed?	prior to	completion	of cause of
	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place o	of Death (C	1 Yes	2)X No	1 □ Y€	s 2 No	
5	Physician: this certific ral director,	2	1 ☐ Yes 2 No	lospital: 1 X Inpati	ent 2 EF	VOutpatient	3 🗆 DO	Other					G □Other (Sp	ecify)	
	ding P	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury Year) 21	Bb. Time of Injury		c. Injury a Work?			d. Describe	how injur	occurred /		
UNISION	of or Attending after death. I Director: After In by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	iury - At home	e farm stre	M (actor)		es 2 N		Location /	Circot	d Number or F	2	
_	afor after t Dire	Certification;	4 Homicide determined	building, e	tc. (Specify)	o, iaiii, stie	et, ractory,	OIIICe		201	City or To	wn, State	yumber or r	Hu <i>rai H</i> oute N	umber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (	29a Certifier (Check only ane) Certifying Physical Exemi	sician: To the best	of my knowle	edge, death	occurred a	t the time	, date and	place, and	due to the	cause(s)	and manner a	as stated.	
	the thin 2 the Formplete	Med	29b. Signature and title of certifier	and manner st	ated.			License r			at the time,				
1	- 3 - 3		1 Chinklin	Guo.	mo		230.						signed (Mor		·
	1	-	30. Name and address of person who co	empleted cause of c		3a) (Type, F	Print)	W05	1855 19/1 in	(Ins)		14100	4 18	200	4-
	U		5hol Roch	Rover	2 B	0	Vard	The same	Balo	4ms	ne	12	y 18,	239	
	Stat Registra	te ar	31. Date filed (Month, Day, Year) MAY 1 9 2004	32 Registr	rar's Signatur	L	lon	1			,				

Brand M. Curry  A Feethy Name of most institution, pive states and mode?  Browned Co. Gen.  Browned Co			1 - For State Registrar	State of Mar	•	epartment of Certificate of			ene g. No. 2001	1593	
## Facilities of Provincial Provincial Co. Gen.    Furnish Broward Co. Gen.   Security According to Security A			_		Curr	1		Month	Day Year	3. Time of Death	
218—44—3774   CM 2   CM	X.		Howard Co. Ger	1.		Coli	rm pta		Howar	-d	
100. State   100. Country   100. C	Director		218-44-3774	M 2 F		Months Days		(Month, Day,	Year) Coi	untry)	
The part of the disease of the part of the	e Maryland la-f show	ctor	10a. State 10b. County	1						10d. Inside City Limits 1X□Yes 2□No	
The part of the price Medician Last Winston  Robert Winston  R	th with th	al Dire					5	10		untry?	
The part of the pa	036  urs after dea al', or Itams Erain arrin	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	er in U.S.			Specify Yes or No- to Rican, etc.)	Black, White	etc.	
The part of the price Medician Last Winston  Robert Winston  R	1215-U within 72 ho ane. then netur	mpleted	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done ife. DO NOT use retire	during most of wo	rking			
20. Hemore of Disposition fluring of Town, State 2   20. Leatien - City or Town, State 2   20. Leatien - Cit	Ind 2 be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)	-					aiden Sumame)		
Continued to State   Continu	C W 14 F						t and Number or R		City or Town, State, Z.		
Privisician / / / / / / / / / / / / / / / / / / /	MOFE, Pages 1 a nent of Hei nut: If item iry or othe		1 XBurial 2 Cremation 3 CR		20b. Place of C cemetery,	Disposition (Name of crematory or other pla	асө)	Date 20	Oc. Location - City or 1		
Physician / Medical Examiner    Physician / Medical Examiner	Balti permit. Departi Imports any inje		21. Signature of Funeral Service License	he			•	Baltim 1101 E.			
State   Stat	/Medical Examiner -transit	¥.	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	ue to (or as a c	eral consequence of extensions	Vascular Mellitu			st,	Approximate Interval Between Onset and Death 2 years	
The stage   Stage	death certific	dical	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum Yo	1 Live birth 2 { 4 Pregnant at tir	Fetal death					•	
autopsy performed? death?    The standard of t	<b>ග්</b> 8 සිදු	by	Part II. Other significant conditions con  End-Stage	- 0		he underlying cause g	ven in Part I.		V		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and determiners of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	The la	Complet	the pertension					autopsy performe	prior to co	ompletion of cause of	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and detection who completed cause of death (Item 23a) (Type, Print)  10c. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  10c. Certifier (Check only one)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	ion of VIta inding Physician ath. ir: Atter this certifi ie funeral director	examiner? 1   Yes 2   We Hospital: 1   Inpatient 2 X FR/Outpatient 3   DOA Other: 4   Nursing Home 5   Residence								(fy)	
5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D., 5755 Cedar Lane, MD. 21044 (Columbia	DIVIS ital or Atte its after de rat Directo		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,								
5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D., 5755 Cedar Lane, MD. 21044 (Columbia	the Hosp thin 24 hou the Fune mpletely fil	Medical	one) 2 Medical Exemir	ner: On the basis of ex	ramination and/	or investigation, in my	opinion, death occi	urred at the time, date	e and place, and due t	to the cause(s)	
	T WE O		<b>&gt;</b>	1				i .		-	
State 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature	9				755	(Pedar L	ane,	mo. 21	044 (	olumbia	

DHMH 17 Rev 1/2001

ORIGINAL

			1- For State of Maryland Registrar	/ Department of Health and N Certificate of Death	Mental Hygiene  Reg. No. 2004   593
	Physic /Medi		Decedent's Name (First, Middle, Last)     Charles Edward Cook		2. Date of Death Month Day Year 3. Time of Death May 14 2004 5:55A
1	Exami	ner	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospita	rederick	4c. County of Death Frederick
	Funeral Director		5. Social Security Number  216-38-2366  Usual Residence of Decedent  6. Sex  1 X M 2 F 62	yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Forei Month, Pay, Year) 9. Birthplace (State or Forei Month) Mary Land
	Maryland e-f show	tor		own or Location erick	10d. Inside City Limit
	th with the 23a or 28 ust be not	al Director	10e. Street and Number 5 South Jefferson Street	10f. Zip Code 21701	10g. Citizen of What Country? U.S.A.
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene.  If itam 271s marked other than "netural", or Items 23a or 28e-f show or other traumatic avant, the Medical Ever it at must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  XXYes 2 No. 14 Yes, Give 1961-196	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Decify Yes or No- Decify Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	d within 72 ho jiene. r than "netui ine Madical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Security	16b. Kind of Business/Industry  Government
/land	uld be filed Mental Hyg Irked othe Itic avant,	To Be C	17. Father's Name (First, Middle, Last) Charles Lee Cook	18. Mother's Name	ne (First, Middle, Maiden Sumame) n Wetzel
	1 and 2 sho Health and I am 27 Is ma		E. Wayne Cook, son	12229 Woodsboro Pike,	ral Route Number, City or Town, State, Zip Code) , Keymar, MD 21757
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tropoca.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	o of Disposition (Name of stery, crematory or other place) OLivet Cemetery  May 19,	Date 20c. Location - City or Town, State Frederick, MD
Bal	Depari Depari Impor any in		21. Signature of Funeral Service Licensee  M00255	²Keeney^dand Bastord 106 East Church St	d PA Funeral Home t., Frederick, MD 21701
10	Priysician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Celling cancer	Interval Between
68760,	tificate be executed ig physician and as the burlat-transit	dical	that initiated events resulting in death) Last Due to (or as a consequence of the consequ	ee of):	
.O. Box	requires that the death certific een signed by the attending p nould be detached for use as:	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be dete	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
of Vital Record	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No    24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No    24b. Were autopsy findings available prior to completion of cause of death?
Z.		o Be	25. Was case referred to medical examiner?	Other	h (Check only one)
				Outpatient 3 DOA 4 Nursing Hon	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Division	or Attending latter death. Diractor: After in by the funer	ertification;	1 atural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	Injury Work?"  M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number,
	spital or ours afte eral Dir filled in i	O	29a. Certifier 1 Certifying Physicien: To the best of my knowled	OB. death occurred at the time, date and place, a	and due to the cause(s) and manner as stated
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medicel Exeminer: On the basis of examination one)	and/or investigation, in my opinion, death occurre	ed at the time, date and place, and due to the cause(s)
	3	M	29b. Signature and title of certifier  Figure College	29c. License number 05-010953 L	29d. Date signed (Month, Day, Year) 5 (14(04
_	6		30. Name and address of person who completed cause of death (Item 23a 400 W. SEVENTM STREET	(Type, Print) Frederick MD	21701
	Sta Registr	V 3	31. Date filed (Month, Day, Year)  MAY 1 9 2004  32. Registrar's Signature	Source	
DH	/H 17 Rev 1/20	001		1 Sports	

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dianne M. Cincinnati Ma 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) July 2, 1955 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1□M 2□F New York 48 Yrs. 122-46-3340 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Nedical Examinat must be notified at Forest Hill Md. Harford 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 United States 10 Lockhart Circle, Apt. A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years nail technicial self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be item 27 is marked o Joseph Pepe Dorothy Anderson Pepe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 South Atwood Road, Bel Air, Md. 21014 19a. Informant's Name/Relationship (Type, Print) Thomas Cincinnati/exhusband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the important: If ite any injury or of once. 1 Surial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gdns. 5/17/04 Bel Air, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner ericardial Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Kneumatond Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ierei Director: After this certificate has been signed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 9 2004

Incinnati

32. Registrar's Signature

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State of Maryland / Department of Health and M	lental Hygiene	2	U	U	- September

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last.	State of Marylan			of Health of Oeath		ntal Hygiene Reg. No. Date of Death		3. Time of Death
Physicia /Medic Examin	al	JANE RUSSFIL CL  4a. Facility Name (If not institution, give  Union Memorial Hosp.	AYBORN		4b. City, 1	Fown, or Location		Month 2 Day	County of Death	1625 M
Funeral Director		Social Security Number 6. Sec.	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year If Under	Min.	Date of Birth (Month, Day, Year)		place (State or Foreign intry) inia
ith the Maryland or 28a-f show	ector	10a. State 10b. County  Mid N/A  10e. Street and Number	10c. Cit	y, Town or Lo		Code		10g. Cit	izen of What Cou	10d. Inside City Limits 1 N Yes 2 No
ter death w Items 23a	by Funeral Director	825 Bonaparte Ave.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1   Yes 2   No If Yes, Give X Year or Dates:			21213 ent of Hispanic Or rfy Cuban, Mexical		U	J.S.A.  14. Race - Amer Black, White  Specify: Bla	ican Indian, , etc.
Z I Z I D-0050 od within 72 hours aff gjene. er then "natural", or et the Medical Exam.	Completed b	15. Decedent's Ed. (Specify only highest grad	cation	(Give	dent's Usua kind of wor DO NOT us cler		st of working	16b. K	ind of Business/li	•
Maryland A  d 2 should be filed v  lth and Mental Hygie  27 Is marked other t  traumatic event, 11	To Be Co	11. 17. Father's Name (First, Middle, Last)  Jefferson Davis Long				18. Moth	garet D		Sumame)	
Daltimore, Mary bermit. Pages 1 and 2 sho Department of Health and I Important: It item 27 Is ma any injury or other trauma once.		19a. Informant's Name/Relationship (T)  James Clayborn Sr.  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R	20b. P		Boneper osition (Nam matory or ot	te Ave., B		20c. Lo	or Town, State, Zi	
permit. Pa Departmer Important any injury		<ul> <li>4 Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> <li>Carlton C. Dougla</li> </ul>	s per dv	r	2. Name and Carlton	Address of Facility C. Dougla Cullon St.	s Funera Belto.	al Service , Mil 21217	., rn	
Physician /Medical Examiner  the being fransit	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Directo (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	rest the mode	e of dying, such as	s cardiac or re	Dizkh		Approximate Interval Between Onset and Death
death certific e attending p id for use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	d	Ideath 3	Ectopic pre			111	23d. Date of delik	very Day Year
The law requires that the law requires span lite has been signed by the lagge 2 should be detached.	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	inderlying ca	ause given in Part	l.	23e. Did tobacco u		the cause of death?
10 LL	Be Completed	25. Was case referred to medical				26. Place	e of Death (C	24a. Was an autopsy performed 1 Yes 2 No	prior to co	opsy findings available ompletion of cause of 2 No
or Attending Phy ter death.  Sirector: After this in by the funeral d	Certification; To B	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending 2  Accident investigation 3  Suicide 6  Could not be 4  Homicide determined	Hospital: 1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specification)	28b. Time of Injury	of 2	9c. Injury at Work? ↑ ☐ Yes 2 ☐	28d	5 ☐ Residence  I. Describe how injur  Location (Street an City or Town, State	ry occurred	
To the Hospital or Attention 24 hours after deal To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Medical Exemone)	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	ivestigation,	at the time, date an in my opinion, dea	nd place, and ath occurred	at the time, date and	) and manner as d place, and due te signed (Month	to the cause(s)
N With		29b. Signature and title of certifier  30. Name and address of person who c	Brown J	n 23a) (Tvoa	3	18783	X899	4 M		1,2004
Sta	ate	Michael Barw  31. Date filed (Month, Day, Year)	32. Registrar's Signa	Unix	N	Jemoria.	al Ho	spital	Battin	nore, MI

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of H <i>rtificate of l</i>			ene2004	15936	
	Dhusisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Death	Day Year	3. Time of Death	
	Physici /Medic		Celia		lark-Irving			May	9°, 2004 11:10P		
	Examin	er	4a. Facility Name (If not institution, giv				Location of Death	P1 1 A . 1	4c. County of Dear		
			Doctors Community  5. Social Security Number 6. S		A.L. '. Age (In yrs. last birthday)		Lanham If Under 24 Hrs.	8. Date of Birth	Prince Ge		
	Funeral Director			I □ M 2 🖾 F	92 Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Co	hplace (State or Foreign nuntry)	
			Usual Residence of Decedent					000. 53	1)11   111		
	nylan		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	88-13	Director		Georges	Forestv					1 ☐ Yes 2X No	
	ath with the Marylan s 23e or 28e-f show		10e. Street and Number			10f. Zip Code			g. Citizen of What Co	ountry?	
	eath is 23	eral	7420 Marlboro Pik		dent Ever in U.S. 13.	20747	ispanic Origin? (Sr		USA 14. Race - Ame	nican Indian	
21215-0036	d within 72 hours after death with the Maryland Jiene. I than "neturel", or items 23e or 28e-f show If a Madical Expollment and but notified at	by Funeral	1 □ Never Married 2 □ Married  3 🛣 Widowed 4 □ Divorced	Armed Form  1 Yes  If Yes, Give Year or Da	2 <b>X</b> ] No	Was Decedent of H. If Yes, specify Cuba  1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Black, Whit		
9	2 hou	Completed	15. Decedent's E (Specify only highest gro	ducation	16a. Dece	dent's Usual Occupa	ation	king 16	6b. Kind of Business	Industry	
21	C * 63	nple	Elementary/Secondary (0-12)	College (1-	life.	DO NOT use retired	dining most or worr	ang			
	filed within Hygiene.	S	12	1	Dor	nestics	40.14-11-1-1-11-1	- /F: A4: /-//- A4	Own Home		
and	d ta D e	Be	17. Father's Name (First, Middle, Last					ne (First, Middle, Ma	aiden Sumame)		
Maryland	should be and Mental le marked o	ို	Robert Mahoney		19h Mail	ing Address (Street	Sara By		City or Town, State, 2	Zin Codel	
Ma			Frank Clark	1,700,771117		B Haddon I			20106	p 00d0)	
re,	s 1 and 2 f Health item 27 i		20a. Method of Disposition		20b. Place of Disp				Oc. Location - City or	Town, State	
m0	0 0 = =		1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special		tate	ove Cemete		18-04 A	Alto, Loui	siana	
Baltimore,	permit. Pag Department Importent: I any injury conce.		21. Signature of Funeral Service Lice	nsee					y McFarlan	d	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the death. Do not en ch line.	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a RE	SPIRA	TORY	(FA)	LURE		>2 Days	
	/Medical Examiner		resulting in death)	Due to (d	or as a consequence of);	En	1.000				
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	uted d ansit	Examiner	lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		EPTIC	EMI	A.				
o,	cate be executed bhysicien and the burial-transit		resulting in death) Last	Due to (d	or as a consequence of):		,				
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9	entificating phase the	O I	IF FEMALE:								
O. Box	The law requires that the death certificate be executed tie has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	1 ☐ Live bi	int at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year	
٥	res that the igned by be detact	by Ph	Part II. Other significant conditions	contributing to de	ath but not resulting in the (	underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
rds	w require: been sig should b							1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Onknown	
Records,	awre	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of	
Ä	The lay	mo.						performe	ed? death?	_	
Vital	ysicien: The is certificate hi director, page	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	)		
of V	Physicien: this certific ral director,	ပ္	1 ☐ Yes 2 No	-	patient 2 ER/Outpatie		4   Nursing H	ome 5 Residen	ce 6 □Other (Spe	cify)	
n c		lon:	27. Manner of Death  1/☐Natural 5 ☐ Pending		f Injury n, Day Year) 28b. Time of Injury	Worl	k?	28d. Describe how	v injury occurred		
isio	death. ctor: A the fu	lcat	2 Accident investigation 3 Suicide 6 Could not be	00 Place	of Injury - At home, farm, st		Yes 2 □No	28f Location (Stre	et and Number or Ru	ra I Poute Number	
Division	after Direction by	Certification;	4 Homicide determined	buildin	g, etc. (Specify)	reet, ractory, office		City or Town,		nai rioute Number,	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one)  Check only one)	hysician: To the miner: On the ba and mann	best of my knowledge, dea sis of examination and/or in er stated.	th occurred at the time the time of time of time of the time of time o	ne, date and place, pinion, death occur	, and due to the cau rred at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)	
	To the within To the comp	M	29b. Signature and title of cellulia	200	~0′	D-3	number , 4 5 2-5	290	d. Date signed (Monti	Day, Year)	
_	Ŋ		30. Name and address of person who	completed cause	of death (Item 231) (Type	Principle	Prod	1 4 220	Bowie.	M20716	
	Sta Registi		31. Date filed (Month, Day, Year)	Se 32. Re	gistrar's Signature	raks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death H Under 24 Hrs. Johns Hopkins lobs PITAL 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Hours 1 XM 2 ☐ F 69 494-38-7255 MARCH 17 1935 MISSOURI Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Klyes 2 □ No BALTIMORE MARYLAND N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 402 E NORTH AVENUE 21202 U.S.A. APR 1A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade MOVER MOVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES COLEMAN SR SHALLIE HOGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 BRYANT AVE., 1st Flr., Baltimore, Md., 21217 Peggie Coleman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 □ Donation 5 □ Other (Specify) MT ZION CEMETERY 05-18-04 LANDSDOWNE, MARYLAND 21. Signature of Pareral Per Cal Lights william C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EMBOUSM Immediate Cause (Final disease or condition resulting in death) ULMONARY VOURS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1**X** Yes 2 ∏ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

**Examiner** the death certificate be executed the Box 981 ŏ Records, P.O. the detached ģ signed l has certificate Vital of this After thi Division death. in by t

Examiner Physician/Medical ð Completed Be ٥ Certification: I Director: A d in by the fo To the Funerel cal

**Physician** 

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7 is marked other than "natural", or itams 23e or 28e-f show treumatic event, Ins Modical Examiner must be notified at

72 hours after

and Mental

permit. Pages 1 and 2 at Department of Health ar Importent: If item 27 Is eny injury or other treu QDCs.

Privsician /Medical

Maryland 21215-0036

Baltimore,

State Registrar

24

29b. Signature and title 30. Nam and address

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DO057093

person who completed cause of death (Item 23a) (Type, Print)

NORTH WOIFE Street, Baltimore, MD 2128 Zimme 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAY 1 9 2004

Rogers

			State of Maryland / Department of State of Maryland / Department / Dep			ne 2001.	15039
}	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) RAY WOND DATES		2. Date of Death Month	Day Year 4	3. Time of Death 2,00 PM
	Funeral Director	er	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	andallstown	8. Date of Birth (Month, Dey, Ye 8-7-19	Balto 9. Birth	place (State or Foreign ntry) Va
21215-0036	should be filed within 72 hours efter death with the Maryland of Mental Hygiene. Trarked other then "netural", or items 23e or 28e-1 show imatic event, it a Medical Eventi ar mails to rivillized at	Completed by Funeral Director	11. Marital Status   12. Was Decedent Ever in U.S.   13. Was Dec   14. Marital Status   12. Maried Forces?   12. Yes 2 \( \text{No lif Yes, Sive Year or Dates:} \)   13. Was Dec   14. Yes, Sive Year or Dates:   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Us (Give kind of visite. DO NOT   12th grade   N/A   Carpent   15. Decedent   16. Decedent's Us (Give kind of visite. DO NOT   12th grade   N/A   Carpent   16. Decedent   16. D	Zip Code  21133  cedent of Hispanic Origin? (Spec pecify Cuban, Mexican, Puerto R 2 No Specify:  sual Occupation work done during most of working ruse retired)	ify Yes or No- lican, etc.)	Citizen of What Cou  U S A  14. Race - Ameni Black, White, Specify:  Kind of Business/In Federal	10d. Inside City Limits 1 □ Yes 2 ☒ No ntry? can Indian, etc. Black
Baltimore, Maryland 21215-0036	d 2 should be th and Mental t? Is marked of traumatic eve	To Be	Thomas Dates  19a. Informant's Name/Relationship (Type, Print)  Ray Paige - Daughter  20a. Method of Disposition  20b. Place of Disposition (N	18. Mother's Name  Malinda  ass (Street and Number or Rural  abrook Road Ran  Name of Da	Adams Route Number, Cit dallstown	ty or Town, State, Zip	33
Baltimo	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other <u>once</u> .		¹XXBurial 2 □Cremation 3 □Removal from State ¹4 □Donation 5 □Other (Specify)  Garrison Fo	or other place)  Drest Vet 5-19-  and Address of Facility Mark	2004 Ov	vings Mill Vest Balto, MD	s, Md
768	Medical Examiner project per project p	ical Examiner	d	ode of dying, such as cardiac or	0000	ryy	Approximate Interval Between Onset and Death
.O. Box 68	at the death certificate to by the attending physical tached for use as the backet.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic 4 □ Pregnant at time of death 5 □ Other (state of the pregnancy)			23d. Date of delive	ery Day Year
Records, P.	law requires that been signed as been signed 2 should be de	Completed by Ph		; cause given in Part I.	1 ☐ Yes 24a. Was an autopsy	24b. Were auto	ne cause of death?  pably 4 Unknown  psy findings available mpletion of cause of
Division of Vital F	ding Physicien:  Ater this certification of the director, I	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1  Impatient 2 ER/Outpatient 3  E	-		No 1 □ Yes 6 □ Other (Specif	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ical Certification;		ed at the time, date and place, an	City or Town, Sta	(s) and manner as el	ated
•	To the Hospite within 24 hours To the Funerel completely filled	Medical	29b. Signature and title of certifier, 29b. Signature and title of certifier, 29b. Signature and dress of certifier and dress of c	9c. License number  D Y Y STOT	29d. 8	Date signed (Month,	
1	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2004  32. Registrar's Signature	MD - N	100 HC		

	•	1 = For State Registrar	State of Maryland		cate of L				004	1502
		Decedent's Name (First, Middle, Last	)		outo of E	, cairi	2. Date of Dea		004	3. Time of Death
Physicia	an	MARY	DAVISON				Month MAY	, Day	2004	05:15 AN
/Medic				45-	City Town and	Landing of Danie		16		05:13 71
Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. Cour	ity of Death	
		GOOD SATTAR ITAN  5. Social Security Number 6. Se			ALT IMC	If Under 24 Hrs.	9 Date of Birth		N/A	-la (Ct-ta Ca
Funeral Director			M 208 8 4		nths Days	Hours Min.	8. Date of Birtl (Month, Day	1920	9. Birth	place (State or Foreig ntry) Uryland
land		10a. State 10b. County	10c. City, To	own or Locatio	n			,		10d, Inside City Limit
ges 1 and 2 should be filed within 72 hours after death with the Maryland to of Heatth and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	0	Maruland N/A		$\mathcal{D} = \mathcal{D}$	timore					1 X Yes 2 □ N
1he h	ect	Maryland N/A  10e. Street and Number			of, Zip Code			10a Chinan a	(14/5-1-0	-1-0
with of	by Funeral Director			''				10g. Citizen o		
s 23	ra	2709 Fleetwood Av		10.14		214			u.s.	
er de	un	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of His , specify Cuban	spanic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. H	ace - Ameni ack, White,	
s aft	Ϋ́F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ▼ No If Yes, Give	101	es 2X No	Specify:		Spec	rify:	11 14
ural			Year or Dates:							thite
72 nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give kind	Usual Occupat of work done du	tion uring most of work	ing	16b. Kind of	Business/In	dustry
Mithir De.	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	ilite. DO N	OT use retired)				A	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ira Ma		6th Grade	1		Homemak				Own H	ome
tal H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Suma	ıme)	
should ind Men in marks umatic	၉	William John Turi	ner			Susi	B. Bro	oks		
2 sho and ls my		19a. Informant's Name/Relationship (Ty	rpe, Print)	9b. Mailing Ad	dress (Street ar	nd Number or Rui	al Route Number	r, City or Tow	n, State, Zip	Code)
1 and 2 Health am 27 l		Mary Olszewski (De	aughter)	3877 Mc	Dowell	Lane, Ho	lethorp	e. Mar	uland	21227
of He of He fitem r oth		20a. Method of Disposition	20b. Place	of Disposition	(Name of y or other place	1		20c. Location		
Pages Jent of I Int: If Itu		1 X Burial 2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)	terrioval ironi State	aine Pa			2004	Raltim.	ata l	laryland
	- 1	21. Signature of Funeral Service Licens								
permit. Departr Import. any inju		B	. 1 1	2221	7	of Facility Sch	umunek	Funera	l Home	25
	-	23a. Part1. Enter the disease, or compi	cica			Lane, E			ykand	21213 Approximate
Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  PNELYON  Due to (or as a consequence)	A						Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter oncertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence							170-6-7-7-7-8-6-6
ate b nysic he b	Icai		1.							
ntifica ng pt as t	Med	15.55144.5						1		
The law requires that the death certifical ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		pic pregnancy or (specify)				ate of delive	nry Day Year
that sed to		Part II. Other significant conditions cor	ntributing to death but not resulting	in the underly	ring cause given	in Part I.	23e. Did tol	bacco use cor	ntribute to th	e cause of death?
uires s sign ld be	d by	RENAL INSUFF	FLIENCY				1 □ Ye	s 2 No	3 ☐ Prob	ably 4 □Unknow
w requ	ete									
: The lav cate has	Completed	ATRIAL FIB	CILCATION				24a. Was a autops perform	y	prior to condeath?	psy findings available inpletion of cause of 2 to 2 to 2
certificate	Be	25. Was case referred to medical examiner?			7777	26. Place of Deat	(Check only on	e)		
sic ldii	P _	1 ☐ Yes 2 💢 No	lospital: 1 Inpatient 2 ER/0	Outpatient 3[	DOA Other	4 ☐ Nursing Ho	me 5 🗆 Reside	ence 6 □Ot	her (Specify	1)
	tlon:	27. Manner of Death  1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury	28c. Injury a Work?	at es 2 □ No	28d. Describe ho	w injury occu	rred	
Hospitel or Attending Pl 44 hours after death. Funerel Director: After ti tely filled in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)				28f. Location (St. City or Town		ber or Rura	l Route Number,
Hospit 4 hour Funere ely fille	edical	29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	ge, death occu and/or investig	irred at the time ation, in my opin	, date and place, nion, death occurr	and due to the ca ed at the time, da	ause(s) and mate and place,	anner as st and due to	ated. the cause(s)
To the within 2 To tha complet		29b. Signature and title of certifier			29c. License i			9d. Date signe		Day, Year)
		> Poul MI	)		Dh	0330	4	YAU !	16,2	004
	1	20. Name and address of parson who so	mpleted cause of death (Item 23a	(Type, Print)	-0		, HD	77	0,0	00 7
5		Resina OSIH, 900	I LOCH RAVON	BLUD.	BAL	Tricor	, MD	2123	39	

	Am	en	Item #9, per FH, G831, State of Maryland	l / Depa <i>Ceri</i>	rtment of F tificate of	lealth and I Death	Mental Hyg	iene 2	004	15941
	Dhusisia		1. Decedent's Name (First, Middle, Last)	000	\/		2. Date of Deet	h Day,	Year 3	3. Time of Death
L.	Physiciai /Medica		KOBERT W JU	100E	7		17%#Y	14 0	2004	7.30 PM
	Examine		a Fecility Name (If not institution, give street end number)	0.11	,	4b. City, Town, or I	Location of Deeth	4c. County	of Death	
			PLEASANT YIEW NURSI	NGH	SME !	MOUNT	HIRY	UHK	KOU	
	Funeral		6. Sex 7. Age (In yrs. k	est birthday) _	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace Country)	(State or Foreign
13	Director		Jsuel Residence of Decedent				LANUAR	06 M.96	2 11	) WKKO
	show	1		, Town or Loca	ation				10d.	Inside City Limits
	Mary Fig.	ខ្ន	MD Carroll	Mt. Ai	ry					1 ☐ Yes 2 ☐ No
	h the	2	Oe. Street end Number		10f. Zip Code		1	0g. Citizen of V	Vhat Country?	,
	23a 2	<u>a</u>	4101 Baltimore National Pike		21771			II	SA	
	burs efter death with the Maryle al, or frems 23a or 28a-f show Examiner mast be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S Armed Forces?		as Decedent of H	lispanic Origin? (Spen, Mexican, Puert	pecify Yes or No-	14. Rac	e - American I	
0	of the offer	2	1 Never Married 2 Married 1 Ty Yes 2 No	11	Tes 2√ No	Specify:	0 1 110411, 010.)	Specify		
21215-0020	within 72 hours efter death with the Marylend ene. then "natural; or items 23a or 28a-f show fre Medical Exercites mark to routified at	à	3 以 Widowed 4 □ Divorced Year or Dates: 1943—	45	Λ				BTac:	
5	nat nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usuel Occup ind of work done o O NOT use retired	during most of wor	king	16b. Kind of Bu	usiness/Indust	ry
12	withir ene. then	티	Elementary/Secondary (0-12) College (1-4or 5+)		borer	1)		Const	ructio	n
	filed with Hygiene rther the		7. Father's Nerne (First, Middle, Last)	Lici.	porer	18. Mother's Nan	ne (First, Middle, M			.1
an	should be filed within to Mental Hygiene. marked other than imatic event, the M	0 26	Roy L. Dorsey			Edith	O. Whee]	ler	,	
Maryland	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	and Number or Ru			State, Zip Co	de)
	1 end 2 s Health ar sm 27 ie ther trau	Ì	Mr. Paul A. Dorsey (Brother)	14846	Bushy P	ark Rd.,	Woodbine	, MD 2	1797	
Baltimore,	S = 5 0	1		ace of Disposi	ition (Name of atory or other place	(e)	Date 2	20c. Location -	City or Town,	State
Ĕ	permit. Peges Depertment of I Important: If its any Injury or o		1 Laturial 2 Li Cremation 3 Li Hemoval from State			emetery	5/21/04	Owines	Mills	MD
ati	permit. Pege Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Licensee			UNERAL HO				
00	Pem impo		Volum & Hailt	- 5	Sykesvil	le, MD 21	784 (410	1)-795-1	a (DOA LAOO	193)
×.	<i>i</i>	+	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart tailure. List only one cause on each line.					-	Ap	proximate erval Between
	Physician		STOOK, OF HOUR TAILUTE. LIST ONLY ONE CAUSE OF COURT INTO.							set and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition Bilateral B:	roncho-	-pneumon	ia			Two	Weeks.
п			resulting in death)	as a conseque						
	executed in end ial-trensit		_ b. Stroke						Yea	ars.
	cete be executed physicien end the burial-trensit	Xan	f any leading to immediate	as a conseque	ence of):				\$ 6	
68760,	be e		Cause. Enter Underlying Cause (Disease or injury)  Cause (Disease or injury)  Lagrangian Company (Company Comp						Yea	ars.
189	ficete p physics the	E COLCA	esulting in death) Last	as a conseque	ence of):					
Box	at the deeth certificated by the ettending platacted for use es		d							
	e deeth	2	Part II. Other eignificant conditions contributing to death but not result	ting in the unc	ferlying cause give	en in Part I	23b. Did to	hacco use con	tribute to the	cause of death?
P.0	by the				, , ,		1 □ Ye	-		y 4□Unknown
	ioned by the detack		Senile Dementia							
D.C	The law requires that the deeth certificate be executed at hes been strined by the ettending physicien end page 2 should by detact ad for use es the burial-trensition.		Coronary Artery Disease				24a. Was ar	autopsy ned?	availab	autopsy findings ble prior to
ပိ	hes be	2	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						of deat	etion of cause th?
<u> </u>		5					1 Ye	s 2KNu	1 □ Ye	s 2🖾 No
Vital Records,	Physician: The this certificete ral director, par	b	25. Was case referred to medical examiner?				th (Check only one	9)	_	
of	his hya	- 1-	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ E		3□ DOA Oth	Mursing H	ome 5 Reside			
	After funer	5	1 Netural 5 Pending (Month, Dey Year)	28b. Time of Injury	28c. Injury Work	y at k? Yes 2 □ No	28d. Describe ho	w injury occurr	ed	
isi	Attending I at deeth.	Ž	2 Accident investigetion 3 Suicide 6 Could not be determined 28e. Plece of Injury - At hor	no form stree		Tes ZINO	28f. Location (Str	eet and Numbe	ar or Rural Ro	ute Number
Division	tal or Attending P rs efter deeth. el Director: Atter t led in by the funer.	5	4 Homicide determined 286. Piece of Injury - At non- building, etc. (Specify)	ie, iaiiii, siiee	n, ractory, onice		City or Town		or ribrarrio	ate Namber,
	spital sours nerel filled		29a. Certifier 1⊠ Certifying Physician: To the best of my know	ledge, death c	occurred at the tim	ne, date and place,	and due to the ca	use(s) and mai	nner as stated	d.
	To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in the Maddical Certi	3	(Check only one)  2 Medical Examiner: On the basis of examination and manner steted.	on and/or inve	stigation, in my or	oinion, death occur	red et the time, da	te and place, a	and due to the	cause(s)
	To the comp		9b. Signature and title of certifier		29c. License	e number	29	d. Date signed	(Month, Day,	Year)
	. 1		1 V-15° Wallet		D 30	0469.	Ma	y 17,	2004	1.
	1+1		O. Name and address of person who completed cause of death (Item 2							
		T	B Vellanki, MD; 9055 Chevrolet  11. Date filed (Month, Day, Year)  32. Registrer's Signatu		#100, E	Ellicott	City, MD	21042.		3 3
K.	State Registrar		11. Date filed (Month, Day, Year) 32. Registrer's Signate MAY 1 9 2004	So	all	2				
				//						

DHMH 16 Rev 6/95

			1- State of Maryland / Department	artment of Health and Mertificate of Death		ne .No.2004	15941
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) William Robert Dempsey	4b, City, Town, or Location of Death	2. Date of Death Month	Day Year 7 2004	3. Time of Death 1439 PM
VA	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number)  Washington County Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  XXM 2□ F	Hagerstown If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Washington	lace (State or Foreign
	Director works	).	220-70-2188         47           Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Lower County		Feb. 13,		yland Od. Inside City Limits 1 □ Yes 2√ No
	th with tha M 23a or 28a-f	by Funeral Director	MD Anne Arundel Odenton  10e. Street and Number  1300 Tab Street	10f. Zip Code 21113	10g.	. Citizen of What Cour	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Examana must be collited at	by Funer	WXNever Married 2   Married   1   Yes XXXNo	Was Decedent of Hispanic Origin? (Sperf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23e or 28e-f show other traumatic event, I'm Medical Exercine Inual te notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workir. DO NOT use retired)	ng	b. Kind of Business/Ind	
Maryland	hould ba file d Mental Hy marked oth matic avant,	To Be (	17. Father's Name (First, Middle, Last)  William C. Dempsey, Jr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailir	18. Mother's Name  Maggie I  ng Address (Street and Number or Rura)	Mae Raine	ey .	Code)
ore, Ma	permit. Pagas 1 and 2 should ba filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'a any injury or other fraumatic avent, Item Mode.		Maggie Mae Dempsey (Mother) 1300	Tab Street, Odento	on, MD 21		
Baltimore	permit. Pag Department Important: any injury o		`4 Donation 5 Other (Specify) Metro Cre	ematory 5/19, Name and Address of Facility Hardesty Funeral 1 12 Ridgely Avenue	Home, P.A	Baltimore, A. Jis. MD 214	
8760,	hysician hysician and hysician and hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):		respiratory arrest,		Approximate Interval Between Onset and Death
.O. Box 687	death cartific e attending p od for usa as	by Physician/Medic		]Ectopic pregnancy ] Other (specify)		23d. Date of delive Month	ory Day Year
0	sign d be	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the	
al Records,	n: The taw requicate has been r, page 2 should	Completed			24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of 2 No
f Vit	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death  Other: 4 \( \text{Nursing Hom} \)		e 6 □Other (Specif)	<b>'</b> )
Division of Vital	Attanding or death.	Certification;	27. Manner of Death  1 Natural 5 Pending investigation  2 Accident 6 Could not be determined 2 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury 28b. Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how i	at and Number or Rura	l Route Number,
О	To the Hospital or within 24 hours after To the Funaral Dircompletely filled in I	Medical Cer	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	occurred at the time, date and place, a	nd due to the caus d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
)	To th within To th	Me	29b. Signature and title of certifier	29c. License number DJ 2 3 2 3	29d.	Date signed (Month,	Day, Year)
	\		30. Name and address of person who completed cause of death (Item 23a) (Type,	Court Ita	. Md.	21742	5
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 9 2004  32. Registrar's Signature	ufe			

			1 - For State Registrar <b>AMEND TIFM #19</b> 1	State of Maryla					jiene leg. No. 200	14 15942		
	Physici	an	Decedent's Name (First, Middle, Last)     AILEEI			AYBOCH		2. Date of Dea Month MAY		3. Time of Death 04 12:55 P M		
	/Medic Examin		4a. Facility Name (If not institution, give s		וט	4b. City, Town, or	r Location of D		4c. County of			
			MILFORD MANOR NURS	SING HOME		BALTIM			BALTIM	ORE		
	Funeral Director		5. Social Security Number 211-05-3607  Usual Residence of Decedent	7. Age (In yrs	. last birthday) 87 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth Min. Worth Day JUNE 2	7,1916	Birthplace (State or Foreign Country)		
	yland now		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits		
	e Mar	Director	MD BALTIN	MORE	PIKE	SVILLE				1 ☐ Yes 2 🕅 No		
	with th	Dire	10e. Street and Number	MILL DOAD		10f. Zip Code	01000		IOg. Citizen of Wha			
	ns 23	Funeral	4204 OLD MILFORD N	12. Was Decedent Ever in I	J.S. 13. V	Vas Decedent of H	21208 ispanic Origin	? (Specify Yes or No- uerto Rican, etc.)	14. Race -	U.S.A. American Indian,		
9	within 72 hours after death with the Maryland ane. than 'natural', or Items 23a or 28a-f show he Wedfral Examina the notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give		fYes, specify Cuba I□Yes 21 <b>X</b> No	Specify:	uerto Rican, etc.)	1000	White, etc.		
21215-0036	hours ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:					Specify:	WHITE		
-51:	n "nat	plete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of	it of working				
212	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or Items 23a or 28a-1 show avant, the Medical Exact must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	SALES	S MANAGER	}		WOMENS A	PPAREL		
and	should be filed within Ind Mental Hyglene. marked othar than matic avant, the Mental Hyglene.	Be	17. Father's Name (First, Middle, Last)		CL OV			Name (First, Middle,	Maiden Sumame)	1111.0		
Maryland		<sup>L</sup>	BENJAMIN  19a. Informant's Name/Relationship (Ty)	pe, Print)	SLOV:		SALOI and Number o	r Rural Route Number	r, City or Town, Sta	HILD		
	27 lith		BARBARA YABLON /	DAUGHTER		ORTHGATE		- MELVILL	NV			
Baltimore,	0 0	9	20a. Method of Disposition 1   Magazine Burial 2 □ Cremation 3 □ R		Place of Dispo- cemetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location - Cit	y or Town, State		
ij	: Pages tment of tant: If it		* 4 ☐ Donation 5 ☐ Other (Specify)	BE1		EMORIAL P		/18/2004		_STOWN, MD		
Bal	permit. Pag Department Important: I any injury o		21. Signatur of Funeral Sarvice License	90				SOL LEVINS N ROAD - P		S., INC. E, MD 21208		
			23a. Part1. Enter the disease or complishock, or heart failure. List only on	cations that caused the dea ne cause on each line.	ith. Do not ente	er the mode of dyin	g, such as car	diac or respiratory arr	est,	Approximate Interval Between Onsel and Death		
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	CVV	uli my	gall	4		Collegens		
	Examiner		Constant It lies and distant	200 10 (0) 00 0 00100	quonoc on.		*	,				
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):							
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
8760,	e be e /sician e burit	dical E		I								
9	rtificat ng phy	Φ.	IF FEMALE:									
Вох	death certifica attending ph I for use as t	lan/	23b. Was decedent pre and in the past 12 marchs?	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet	aldeath 3 🗆	Ectopic pregnancy	1		23d. Date of Month	f delivery Day Year		
o.	t the de by the a tached f	Physiclan/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	Other (specify)				,		
<u>α</u>	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Pr	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?		
ord	w require been sig should b	ted	Idyput	ensun				_ 1 □ Y	es 2□No 3[	Probably 4 Unknown		
Vital Records,	e taw r has be je 2 sh	Completed	i) inve	les				24a. Was a autops perform	sy prior	e autopsy findings available r to completion of cause of		
a			OF 18tee case referred to modical					1 Yes	2 1 No 1	Yes 2□ No		
N N	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	ER/Outpatien	t 3 DOA Oth	05	Death (Check only or ng Home 5 - Reside		Specify)		
n of	ding Phys h, After this funeral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun			ow injury occurred			
Sio	Attanding or death. ractor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 No	006 1	46.	010		
Division	after of Dirac	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, tarm, stri ify)	eet, factory, office		City or Town		or Rural Route Number,		
	To the Hospital or Attant within 24 hours after death To tha Funaral Diractor: completely filled in by the	Medical C	29a. Certifier Check only one) Check only 2 Medical Example	sicien: To the best of my kr ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the ting	ne, date and pl pinion, death o	lace, and due to the coccurred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)		
	To the within To the	Me	29b. Signature and title of certifier	1		29c. Licens			9d. Date signed (A	fonth, Day, Year)		
•			<b>)</b>	mo		/	1275	,07	5/17	104		
	3		30. Name and address of person who co	(Jett/eman	^	1838 (	Mer	Tree	Re	21208		
•	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 9 2004	32. Registrar's Sign	de A	ooth						

			1 - For Stete Registrar	State of	Maryland / Dep <i>Ce</i>	ertificate of			ene g. No2 0 0 4	15943
	Physici		Decedent's Name (First, Middle, L     AMELIA LORET		RWEICH			2. Date of Death Month MAY 14,		3. Time of Death 1:20 A M
	/Medic Examir		4a. Facility Name (If not institution, gi		•		r Location of Deat		4c. County of De	ath
47			NORTH ARUNDEL  5. Social Security Number 6.		Age (In yrs. last birthda)	GLEN B	URNIE  If Under 24 Hrs.	8 Date of Birth	ANNE AR	
	Funeral Director		215-28-5656	1 M 2 GyF	72 Yrs.	Months Days	Hours Min.		, 1931	irthplece (State or Foreign Country)  MD.
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or i	ocation				10d. Inside City Limits
	Maryi -f sho	tor	MD. BALTIM	ORE		EASTWOOD				1 ☐ Yes 2 ☐ No
	or 284	Direc	10e. Street and Number	17		10f. Zip Code		10	g. Citizen of What 0	Country?
	eath w	Funeral Director	7238 STRATTON WA	Y 12. Was Decede	ant Ever in U.S. 13	. Was Decedent of H	224	pecify Yes or No.	U.S.A.	nerican Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at ance.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Amed Force 1 Yes 2 If Yes, Give Year or Date	ss? ∏No X	If Yes, specify Cuba	Specify:	o Rican, etc.)	Black, Wh	
5-0	72 hc "natur	eted	15. Decedent's E (Specify only highest g.	ducation ade completed)	(Giv	edent's Usual Occup e kind of work done	durina most of woi	rking	6b. Kind of Busines	s/Industry
121	within iene. than	Completed	Elementary/Secondary (0-12) 6TH	College (1-4	or 5+)	DO NOT use retired EMAKER	3)		OWN HOME	
Maryland 2	uld be filed fental Hygi rkad other tic evant, I	To Be Co	17. Father's Name (First, Middle, Las CHARLES COPPER				18. Mother's Nar FRANCI	ne (First, Middle, Ma ES		
/lar	2 sho		19a. Informant's Name/Relationship					ıral Route Number, (		en more en en en
	1 and Health tam 27 sthar t	13	LEA FORD/DAUGHTE	₹	20b. Place of Dist	osition (Name of		LEN BURNIE	E. MARYLA	
E E	Pages nent of int: If ii		1 ☐ Burial 2 🛣 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec		BACTTMOR CREM	E-WASHING ATORY	řon   5/17		LAUREL, AI	
Baltimore,	permit. Departn Importa any inju		21. Signature of Europa Service Lice	nsee S		22. Name and Addre	ss of Facility CF	HARLES S.	ZEILER &	SON. INC.
	N/C		23a. Part1. Enter the disease cor shock, or heart fail and the first	one cause on each						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	<u>A</u>	CUTE!	MYDCA	RDIAL	ENFA	RITON	Criser and Death
	Examiner			· ·	as a consequence of):	N DEDE	EN. ATTN	ENFA DIAGE	1759	
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence of):					
	arecute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):	12 .				
68760,	icate be executed physician and s the burial-transit	edical E		d						
9			IF FEMALE:	00-16					1	
P.O. Box	The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
of Vital Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions		h but not resulting in the	underlying cause giv	en in Part J.			to the cause of death? Probably 4 💆 Unknown
eco	e taw re has bee je 2 sho	Completed	CHROMIC O	BSTRUC	TIVE P	MEMONA	My DIST	4a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
al R								performe	ed? death? No 1 ☐ Ye	s 2 <b>X</b> No
V.	rsiciar s certif lirecto	o Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes \( 2 \sum \) No	Hospital:	atient 2 ER/Outpatie	ont 3□ DOA Oth		th <i>Check onlone</i> ome 5□Residend		anife)
n of	ding Physician: The Ih. After this certificate ha funeral director, page		27. Manner of Death 1   Matural 5 □ Pending	28a. Date of I				28d. Describe how		өспуу
Division	Attanding Physician: r death. actor: After this certifici by the funeral director,	icatic	2 Accident investigate 3 Suicide 6 Could not			M 1 🗆	Yes 2□No	006 1		
Div	al or A	Certification:	4 Homicide determined	building,	Injury - At home, farm, s etc. (Specify)	reet, factory, office		City or Town,	et and Number or F State)	Rural Route Number,
	To tha Hospital or Attanding F within 24 hours after death. To tha Funaral Diractor; After completely filled in by the funer.	Medicai (	29a. Certifier (Chack only one) 1 Certifying P 2 Medical Exa	hysician: To the be miner: On the basis and manner	ast of my knowledge, dea s of examination and/or i stated.	th occurred at the time	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner a e and place, and du	us stated. re to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		A	29c. License		290	I. Date signed (Mon	oth, Day, Year)
	0,				doub (transcription	Brien)	1743	3	5-14-	-0 ¢ ·
	,		30. Name and address of person who	72MAS	To death (Item 23a) (Type	. Frint) 7/0(	HURCH	+ ST-B	ALTIMO	-04 · RE, MD2122
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	back				

DOTTERW elch, Loretta

fin 24 hours a ø State

Registrar MAY 1 9 2004

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

White Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

200

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

14, 2004

MAY

Baltimore, Maryland 21215-0036

Box 68760,

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY 13. Physician Robert Lee Ellis 2004 12:21 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL HOSPITAL CENTER WESTMINSTER CARROLL CO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F 215-74-4156 42 Yrs Director 31 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f ahow Md Carrol1 Sykesville 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 Gaither Manor Drive 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give A Year or Dates: 1 Never Married 2 Married 9 1 ☐ Yes 2 🗓 No Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) construction drywall/construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental 7 is marked of Edgar Allen Ellis Hazel E. Pettitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if item 27 is any injury or other traum Barbara Ann Ellis (spouse) 1012 Gaither Manor Dr., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 5-18-04 Marriottsville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Page Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** atherosclerotic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed physician and s the burial-transit Due to (or as a consequence of): Completed by Physician/Medical anding pl use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery atten tor us 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death signed by the at d be detached to 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No should b 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1XYes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No Certification: To 1 Inpatient 2 XER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th
completely tilled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

D

31. Date filed (Month, Day, Year)

MAY 1 9 2004

32. Registrar's Signature

OCME

MAY 14, 2004

111 Penn Street, Baltimore, Maryland 21201

			1 For State	State of M	aryland /						lental Hy	gien	e	1	1 = 2 1 0
			Registrar  1. Decedent's Name (First, Middle,	( act)	**	Ce	rtificate	e of L	Jeath		0 D-14 D	Reg. No	200	i.	15946
11.	Physic	ian	1. Decedent's Name (First, Middle,	Last)	~ 1						2. Date of De Month	eath احک	ay Ye	ar, 1	3. Time of Death
Y	/Medi Examir		4a. Facility Name (If not institution,	nive street and number	111	,	4b City	Town or	Location of	of Death	05	1 _2	c. County of D	Jan J	2. √2 V.
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I	Funeral		- 0, 0, 0, 1,	Sex 7. Ag	e (In yrs. last	birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi	rth		Birthpla	e (State or Foreign
	Director		217-09-0442	1 <b>X</b> 1M 2□F	83	Yrs.	MOTHES	Days	nours	Min.	Nov 25	y, real	920 Ma	Country L	()
	and #		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation		***					100	. Inside City Limits
	Mary f sho	ō	Maryland Queen A	4nnes	Queens									100	1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		Queens	SCOW	10f. Zip	Code				10g. Ci	tizen of What	Country	1?
	23a o	a D	102 Dudley Ave	enue				2	21658			Un	ited S	tate	es
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	<b>)-</b>	14. Race - A Black, W		
36	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23s or 28s-1 show the Madical Examinat must be rediffied at	by Fu	1 ☐ Never Married 2[X] Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ I	No	j	1 ☐ Yes 2		Specify:	,			Specify:		ite
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiane. If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show or other traumatic event, the Madical Examiner must be refulled at		Mildred Downey / 20a. Method of Disposition	Daughter	20b. Place	360 ( of Dispo	SICOVE sition (Name	Cree	ek Ro		Centre		e, Mar	•	d 21617
õ	Pages nent of int: If its iry or o		1 Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe		cemet	ery, crer	natory or ot ark Ce	her place	erv		/2004				ryland
Baltimore,	그 문문을		21. Signature of Funeral Service Lie				. Name and		- :		bbard I				
Ä	Depa Impo any ir										e, Balt	imo	re, Mai	ryla	nd 21229
		2	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	the death. Do	not ent	er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,		A	oproximate terval Between
1	Physician	1	Immediate Cause (Final disease or condition	COAN	ical .	ster	10115	LN	4	N42	Worth	da			nset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence		1		la la		14	7		1	
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	ted nsit	nin.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 to (or as			. L.	ul c						.4.	1/ -
Ć	execun n and ial-tra	Examine	that initiated events resulting in death) Last	C. Due to (or as	a consequence	€ 60 h e of):	/ / ۷.	ण ५						m	MANS
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89 )	artifica ing ph e as th	Med	IF FEMALE:		-										
Вох	ath certific ettending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal deat		Ectopic pre						23d. Date of o	delivery Da	y Year
o.	he de?	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡ Unknown	time of death	5 □	Other (spe	cify)					MONIT	Da	у төаг
P.O.	that the de led by the detached		Part II. Other significant conditions	contributing to death by	ut not resulting	in the ur	derlying ca	use giver	n in Part I.		23e. Did to	obacco u	ise contribute	to the c	ause of death?
Vital Records,	en sign	d by	Hypertonian								101	res 21	No 3□	Probably	y 4 ∐Unknown
00	sw requ	olete	Contra esochene	? Nellow di	seare						24a. Was	an	24b. Were	autopsy	findings available
Re	The lav	Completed	Chamaic Pa	in San	Leion	ربل	rosis				autop perfo 1 ☐ Yes	rmed?	prior to death?	o comple	etion of cause of No
		Be	25. Was case referred to medical examiner?	Clore	SWITTON	3	1,0010		26. Place	of Death	Check onle o	2 <b>x</b> No ne		93 ZE	s NO
of V	di is	은	1 ☐ Yes 2 No	Hospital: 1 Inpatie		utpatien	3 □ DOA		4 % Nur		e 5 ☐ Resid			pecify)	
	ing F	i o	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury		c. Injury a Work?			8d. Describe h	ow injur	y occurred		
Division	Attending ir death. ector: After by the fune	Icat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be 200 Place of lair	iry - At home if	arm stre	M factory		es 2 □ N		8f. Location (S	Straat an	d Number or I	Dural Da	nuto Alumbor
ō	tal or Attending Pt s after death. al Director: After th ed in by the funeral	Certification;	4 Homicide determine	building, etc	c. (Specify)	, 5,,,	, iacioty,	011100		- 11 -	City or Tow	m, State	)	i iurar ric	oute Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th		29a. Certifier 1 Certifying F	Physician: To the best of	of my knowledg	e, death	occurred a	t the time	, date and	place, a	nd due to the o	ause(s)	and manner	as stated	d.
	the Hi in 24 the Fi	edical	one)	aminer: On the basis of and manner sta	examination a ted.	nd/or inv	estigation, i	n my opir	nion, death	OCCUTE	d at the time, o	date and	place, and du	ue to the	cause(s)
	To To To	Σ	29b. Signature and title of confirier	1	-	110		License	number			29d. Dat	e signed (Moi	nth, Day	Year)
	11		1 March			MI		70C	ソリソ	17	8	3	17/04		
	5		30. Name and address of person who												
-	Sta	te	Dr. Cosenza, MD, 31. Date filed (Month, Day, Year)	420 Pennsy 32. Registra	Lvania r's Signature	Ave	nue, (	entr	evil	le, I	Marylar	ad 2	1617		
Y C	Registra		MAY 1 9 200	4	14. 1	Francis	40								

				1 - For State Registrar			nd / Dep	artment of I	Health and N	∕lental Hv	aiene		15017
							Ce	rtificate of	Death			2004	1994/
		Physici	an	Decedent's Name (First, Middle,		1 1)	PAR	1		2. Date of De Month	ath Day	Year	3. Time of Death
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	4	Examir	ner	4a. Facility Name (If not institution, g	give street and nu	ımber)		4b. City, Town, o	or Location of Death		4c.	County of Death	
				627 B STREET  5. Social Security Number 6	. Sex	7. Age (In yrs.	last histoday	PASAD If Under 1 Year	ENA If Under 24 Hrs.	9 Date of Di	A	NNE ARUN	
	В	Funeral Director	Н	216-46-3995	1∭M 2□F	49	Yrs.	Months Days	Hours Min.	8. Date of Bi	ay, Year)		place (State or Foreign htry)
4				Usual Residence of Decedent						May 05	0 190	5   Mary	vland
		rylan Thow		10a. State 10b. County		10c. Ci	ty, Town or L	ocation				1	0d. Inside City Limits
U		Ba-f a	cto		rundel (	Co.	Pasad	ena					1 ☐ Yes 2 📉 No
A		vith th	Die	10e. Street and Number				10f. Zip Code	2.0		10g. Citiz	ten of What Cour	•
0		s 23e	Funeral Director	627 B Street	10 Was Day	adam Francis I	1.0	211:				U.S.A	
士		ter de	un.	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed F	edent Ever in U orces? 2   No	J.S. 13.	If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	)	<ol> <li>Race - Americ Black, White,</li> </ol>	
FISCHBACH	5-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Exeminer must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or [	ive	-	1 ☐ Yes 2 🗓 No	Specify:			Specify: Whi	ite
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a	Z	2 should be to and Mental I is marked or raumatic eve	T <sub>o</sub>	19a. Informant's Name/Relationship		SCIIDACII		ng Address (Street	Martha  and Number or Run			Kamins	
DWARI	altimore, Maryland	s 1 and 2 should if Health and Men item 27 is marke othar traumatic		Joseph F. Fischl		Brother			, Pasader				0000)
A	Je,	s 1 a of Hea item otha	1	20a. Method of Disposition		20b. F	Place of Disponent	osition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or To	own, State
X	Ē	Page nent c nnt: If	- 8	1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe	⊔Removal from cify)				tery 05/1	5/04	Balt	cimore.	Md .
111	alt	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Sorvice Lic	ensee		2	2. Name and Addre	ss of Facility y-Polynial	le Frances			
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	V A	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition				ter the mode of dyir	ARCTION	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	200	/Medical Examiner		resulting in death)		(or as a consec							
			-er	Sequentially list conditions,	b. Lue to	(or as a conseq	เนษกรษ บกิ.						
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	o,	ie be executed ysician and e burial-transit		resulting in death) Last	c. Due to	(or as a conseq	uence of):						
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	Box	ath ce Itendi or use	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome of pregna pirth 2  Feta	Il death 3[	Ectopic pregnancy	,		23	3d. Date of delive	
	o.	the all	Completed by Physician/Med	1 Yes 2 No	4□Pregi 9□Unkn	nant at time of d own	leath 5	Other (specify)				Month	Day Year
1	σ.	that the d ed by the detached	P.	Part II. Other significant conditions	contributing to g	eath but not res	ulting in the u	nderlying cause giv	en in Part I	23a Did t	obacco us	e contribute to th	e cause of death?
	ds,	uires tha signed I id be det	d by	. 1	10 107C4	A1504		DIABETT		1 10/	/		ably 4 □Unknown
	50	w requires been sign should be	ete	MAYLITUS TO	1852	- 1	PIGN.		<u></u>	24a. Was			
	Re	he la e has ige 2	mc.	10/00/1107	10 00	() 116	FIGIV.	3100		autor	rmed?	prior to con death?	psy findings available inpletion of cause of
	ta	ifficat or, pa	e C	25. Was case referred to medical	T				26 Place of Death	1 Yes		1 🗆 Yes	2 No
	>	ysician: The is certificate hadirector, page	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	26. Place of Death er: 4 Nursing Ho	-		Other (Specific	r)
	0	ng Ph ter th	L:u	27. Manner of Death	28a, Date		28b. Time o		y at	28d. Describe I			)
	io	endir sath. or: Af he fur	atic	2 Accident investigat	ion	,,	,оту		Yes 2 □ No				
	Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	3 Suicide 6 Could not determine	288. Place	of Injury - At he ing, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or Rura	Route Number,
		e Hospit 24 hour e Funera etely fille	Medical (	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	aminer: On the b	best of my kno asis of examina ner stated.	wledge, deat ition and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
		To the within To the comp	M	29b. Signature and title of certifier	10/			29c. Licens	e number		29d. Date	signed (Month, L	Day, Year)
		XI		1 Church &	Mho	MIL		DZ	1336		5	12/04	
		X		30. Name and address of person wh	o completed cau	se of death (Iten	п 23а) (Туре,	Print)	to 1 .		1 .	, ,	2420
				31. Date filed (Month, Day, Year)	n N	logietraria C:	800	18 K	ime	, +	wy	1 6	ナリノナ人
		Sta Registr		10 2004 1 9 2004	Even	legistrar's Signa منصعر	G	low to			1		

			1 - For State Registrar		aryland / Depa		of Health a of Death		Reg. No	2001	15948
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, La     GEORGE W      4a. Facility Name (If not institution, given the content of the cont	FITCH e street and number)		4b. City, Tov	wn, or Location of	Mo M.	te of Death onth Da AY 15	y Year 2004 County of Death	3. Time of Death  5:15p
	Funeral Director		213-20-8569		Rehab e (In yrs. last birthday) 80 Yrs.	If Under 1 Y	stertow Year   If Under 2 ays   Hours		te of Birth Onth, Day, Year) 26/1924	Kent  9. Birth Con  Mar	place (State or Foreign intry) rvland
	72 hours after death with the Maryland naturel; or Items 23e or 28s-f ehow lites Event of must be notified at	ai Director	Usual Residence of Decedent  10a. State  10b. County  MD  Kent  10e. Street and Number  20664 Mercer A	/enue	10c. City, Town or Lo				10g. Cit	tizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2X No
215-0036	nin 72 hours after dea n "naturel, or Items Medical Evan. et m	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  15. Decedent's E (Specify only highest gr.	ade completed)	16a. Dece	1 ☐ Yes 2 🔀	ccupation		es or No- etc.)	14. Race - Ameri Black, White	ite
Maryland 21215-0036	should be filed within 72 ho nd Mental Hygiene. I marked other than "natur umatic event, the Medical	To Be Com	17. Father's Name (First, Middle, Last  John William Fit  19a. Informant's Name/Relationship (	ch	Cra	ine Ope	rator 18. Mother Els	ie May	Middle, Maiden Finney	,	•
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Important: if Item 27 ie marke eny injury or other traumatic <u>once</u> .		Leroy W. Fitch  20a. Method of Disposition  1 XBurial 2 Cremation 3 C  4 Donation 5 Other (Special Signature of Funeral Service Lices)	(SON) Removal from State	206. Place of Dispo cometery, crer Bel Air Me	sition (Name on atory or other emorial Name and Ac	cer Aven	Date - Ro Date -	ock Hall 20c. Lo 004 Ba Lassahn	el Air, Funeral	21661 own, State
8760,	be attending physician and buriatiransii and for use as the buriatiransii	dical Examiner	23a. Part1. Enter the disease, of comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	b. Due to (or as	a consequence of):	er the mode of		ardiac or respir	alory arrest,		Approximate Interval Between Onset and Death
P.O. Box 6	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregna Other (specify			-	23d. Date of delive Month	ery Day Year
	The law requires that the de ate has been signed by the a page 2 should be detached	þ	Part II. Other significant conditions of	Artery	ut not resulting in the ur	-	given in Part I.	236			he cause of death?
tal Rec	2 2 3	e Completed	25. Was case referred to medical					1 🗆	t. Was an autopsy performed? Yes 2 No		psy findings available mpletion of cause of
Division of Vital Records,	ding P	Certification: To B	examiner?  1 Yes 2 No  27 Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be determined		y 28b. Time of Injury	28c. I	Other: 4 Nurs njury at Work? 1 Yes 2 No	28d. Des	Residence 6	d Number or Rura	
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one)  Certifying Ph	ysician: To the best on hiner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the	e time, date and j ny opinion, death	place, and due occurred at the	to the cause(s) a time, date and	and manner as st place, and due to	ated. the cause(s)
	with com	×	29b. Signature and title of certifier  30. Name and address of person who		eath (Item 23a) (Type, F	DO	ense number 0051786	5	29d. Date	signed (Month, )	Day, Year)
	Sta Registr	-	Andrew S. Feromotion (Month, Day, Year)  MAY 1 0 2004		r's Signature	peer 1	Rd. Che	esterto	own, M	D. 2162	20

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 15, **Physician** 2004 11:53 AM Sandra Louise Figgins /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford 894 Oxford Avenue Aberdeen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 17, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 📉 Days Hours Maryland 58 1945 Director 219-42-5520 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Aberdeen Harford Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 894 Oxford Avenue 21001 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ant: if Item 27 is marked other than "natural", or ite ary or other traumatic event, the Medical Examina 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Adult Handicap Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Transportation 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Dorothy Cudnik S. Robusto Robert (nmn) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1029 Day Road, Sykesville, Maryland 21784 Sharon L. Naylor - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Bel Air Mem. Gardens 5/19/04 Bel Air, Maryland 21. Signature Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardia **Physician** minutes resulting in death) /Medical Due to (or as a consequence of): Examiner Cronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year jo in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Ø No P.O. been signed by the should be detached 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 2 🗆 No 1 Yes 2 XNe 1 Yes Division of Vital fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home SPResidence 6 Other (Specify) 0 1 ☐ Yes 2 🛛 No 3 DOA this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D53186 May 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. M. Phail Rd Bel Air MD 21014 TINNE MD JULIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004 MAY 1 9

			1 _ For	State of Ma	arylan				Mental Hygie	ene 2 n n	4 15950
			Registrar  1. Decedent's Name (First, Middle, La	eti		Ce	rtificate of	Death	2. Date of Death	. No.	
	Physic		S/ 0./ 1-10	F/ when	hair	ha			Month	Day Ye	ar 3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, git		7.200	171	4b. City, Town, o	r Location of Dea	th J	4c. County of D	eath 7 P
			NORTHWEST HOSPIT	AL CENTER			RANDALL	STOWN		BALTIMO	)RE
	Funeral Director			Sex 7. Ag	e (In yrs. I	ast birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		<sup>(ear)</sup> 1947	Birthplace (State or Foreign Country) MD
	show		Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Man a-f sh	ţċ	MD BALT	IMORE		OWIN	GS MILLS				1 ☐ Yes 2 📈 No
	or 28	Dire	10e. Street and Number				10f. Zip Code		10g	. Citizen of What	Country?
	s 23a	rai	8007-A GREENSPRI	T	-			21117			U.S.A.
215-0036	be filed within 72 hours after death with the Maryland Ital Hyglene. Id other than "natural", or Itams 23a or 28a-f show event, the Medical Examinar results notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🂢 Divorced	12. Was Decedent Amed Forces? 1 Tyes 2 1 1 Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. WHITE
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	lent's Usual Occup	during most of we	ndkina 16	b. Kind of Busine	ss/Industry
121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I	OONOT use retired MS EXAMIN	d) -		TATE OF	MARYLAND
d 21	filed withi Hygiene. other than ent, the N	Be Co	17. Father's Name (First, Middle, Last			CLAI	12 EVALITION		me (First, Middle, Ma		MARTLAND
Maryland		To B	JACK			FLOM	ENBAUM	DORIS			COPELAND
lan	2 sho and 1 Is me		19a. Informant's Name/Relationship (						ural Route Number, C		e, Zip Code)
	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		GAYLE FLOMENBAUM  20a. Method of Disposition	- DAUGHTE			CARAWAY sition (Name of	ROAD. AF	-		TOWN, MD 2113
nor	0 0		1 X Burial 2 ☐ Cremation 3 ☐		СӨ	metery, cren	natory or other plac			c. Location - City	
altimore,	artm orta inju		'4 ☐ Donation 5 ☐ Other (Specifical Service Licer	-	SIL		ZION CEME  . Name and Addres		DL LEVINSOI	ROSEDA	
Ä	Depa Impo any ir		16bert H	1=	<b>-</b>	8	900 REIST	ERSTOWN	ROAD - PII	KESVILLE	, MD 21208
г			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. ne.	Do not ente	er the mode of dying	g, such as cardia	c or respiratory arrest		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Syptic	- S/2.	ock					Onset and Death
*	Examiner		- (	Dye to (or as:	a consequ	ence of):					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underwind	Due to (or as	a conseque	ence of):		,			
	and trans	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Stapl	14/00	OLLU	LS AW	TOMS.	Dec Zerop	40	
68760,	ficate be executed physician and s the burial-transit			Duĕ to (6r as a	a donseque	ence or);			•••		
		edical		d							
P.O. Box	that the death certificated by the attending posterior of the detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1☐Live birth 4☐Pregnant at 9☐ Unknown	2 Fetal	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resul	ting in the un	derlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ords	w require been sig should b		multi orpan	failure					1 🗆 Yes	2 □ No 3 □	Probably 4 DUnknown
Vital Records,	has be	Completed							24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
al H	T ate								performed 1 ☐ Yes 200	? death	?
Z.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			3CI DOA Othe		ath (Check only one)		
of	g Phys er this eral dii	H-11	1 Yes 2 No 27. Manner of Death	28a. ate of Injur	y 2	R/Outpatient 28b. Time of	3 DOA 28c. Injury Work	4 Li Nursing H	lome 5 Residence		pecify)
ion	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day	Year)	Injury		:? ∕es 2 □No		,,	
Division	al or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hom . (Specify)	ie, farm, stre	et, factory, office		28f. Location (Stree City or Town, St	and Number or late)	Rural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best on hiner: On the basis of and manner state	examinatio	ledge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the cause rred at the time, date	e(s) and manner and place, and de	as stated, ue to the cause(s)
	To t To t	X	29b. Signature and title of certifier				29c. License		29d.	Date signed (Mo	nth, Day, Year)
7	1.		Alike 1-	11.1			17	43174	7 Ing	415,	1206
	10		30. Name an address of person who	completed cause of de	ath (Item 2	23a) (Type, F	Print)	+1	A. 1	-	A
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	гө	1 1286.7		Ca 4461114	441	hyary Krad
	Registr	ar	MAY 1 9 2004	Selw	v	6 1	parks				

Willie Gibbs 04-03287 MAN 1 - For State Registrar

**Physician** 

/Medical

**Examiner** 

Decedent's Name

4a. Facility Name (If

10a State

5. Social Security Number

214-64-7438

Usual Residence of Decedent

10b. County

6. Sex

**™**M 2□F

os P	Please Type or Print in	Black Indelible Ink. En	sure All Copies Are Leg	ible.
For	State of Maryla	nd / Department of Healtl	n and Mental Hygiene	
State Registrar		Certificate of Dea	th Reg. No. 21	004 15951
Decedent's Name (First,	Middle, Last)		2. Date of Death	3. Time of Death
Will:	ie	Gibbs	May 15, 2004	0202 A M
Facility Name (If not ins	titution, give street and number)	4b. City, Town, or Location	on of Death 4c. Count	y of Death
Sinai Hospi	ital	Baltimore	e NA	4

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10-3-57

Birthplace (State or Foreign Country)

10d. Inside City Limits

XXYes 2 □ No

Va.

14. Race - American Indian, Black, White, etc.

Black

21202

Approximate Interval Between Onset and Death

USA

Specify:

Howard

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No

Year

Month

**Funeral** 

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or Items 23e or 28e-f ehow 7 is marked other then "naturel", or Items 23e or 28e-f ehow treumatic event, "Le Medical Exarch et must ke nodified at item 27

Baltimore, Maryland 21215-0036

permit. Pages Department of Important: If it any injury or o Physician /Medical Examiner

iclan and burial-transit physiclan a Box 68760 use as for P.O. signed by the a Division of Vital Records, page 2 s death.

To the Hospitel or Attending Physicien: The law requires that the death certificate be after death Director: filled in by within 24 hours a: To the Funerel C completely filled i

Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 4015 Woodhaven Ave. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Machine Mechanic High Image 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie P Gibbs, Sr. Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carnita Gibbs Wife 4015 Woodhaven Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 5-21-04 Randallstown, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Baltimore, Md. 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCLEROTIC disease or condition resulting in death) CARDOVASCULAN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Winknown Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 | Inpatient 2CXER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) P 1 X Yes 2 □ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 🖄 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 1 O.C.M.E. May 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MO 111 Penn Street, Baltimore, Maryland 21201

7. Age (In yrs. last birthday)

46

Yrs.

10c. City, Town or Location

State

Registrar

31. Date filed (Month, Day, Year)

32. Registar's Signature

1 9 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Greene May 2004 11:45 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Futurecare - Chesapeake Arno1d Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. | 14, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 70 153-26-0249 1933 Director New Jersey Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at Anne Arundel 1 ☐ Yes 2 📉 No Crownsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 1008 Tudor Drive 21032 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2XNo White Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nt eny injury or other traumatic event, the Mudit page. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Larsen Elizabeth Moller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles W. Greene (Husband) 1008 Tudor Drive, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 5/21/2004 Crownsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Hardesty Funeral Home, P.A. Thomes 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** erebroras /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 10 No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 I Hakaawa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þe 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate 2 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 □ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Watural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b Signature and title of certifier 29e License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eterans Hwy M. Clers v. C er 8601 Riedir DOLEN 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene  $2 \bigcap \bigcap \bigcup_{i}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Henry 29 M MAS /Medical 4a. Facility Name (If not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore NA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**□**M 2□F Yrs. Director S.C 80 6-12-23 247-20-6190 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other then "natural", or Items 23a or 28a-f shovent, the Medical Examinar must be notified at 1 X Yes 2 □ No Directo Md. NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5009 Frankford Ave Funerai 21206 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ρ 1 ☐ Yes 2 🟋 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Bob Flathman Construction Cement Finisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is markad William Grissitte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health i <u>Pattie Grissitte</u> Wife 1700 N. Gay St. Apt. 109, Baltimore, Md. 21213 Important: If Item any injury or otha 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Voshell Mem. Garden 5-20-04 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21204 Baltimore, Md. lady March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCONCLIA INFAVCTION thous /Medical Due to (or as a consequence of) Examiner heruscle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed IABETES Due to (or as a consequence of): Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death signed by the aid be detached to 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No Hospital: 2₽ ER/Outpatient 3□ DOA 1 Inpatient this To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 35102 Mann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIDGE RUAD DON 104 31. Date liled (Month, Day, Year) 32. Registrar's Signature MAY 1 9 2004 Registrar

			1 - State RegistaMEND TIEM #19a I	State of Mary					/	15951
			1. Decedent's Name (First, Middle, Last)	TRING GOLD	2)(04 3000)	tilicate of t		2. Date of Death	ig. No 0 0 1	3. Time of Death
	Physicia			7		По	10 n n n n	Month	Day Yeer 1.5 0.4	I M
	/Medic Examin		Willie 4a. Facility Name (If not institution, give s	Jas treet and number)	per		Location of Deeth	May	4c. County of Dea	12:00p."
	Examin	•	1743 Waverly W	av Apt B		Baltim	ore			
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Bi	thplace (State or Foreign ountry)
	Director		219-28-0028 Usual Residence of Decedent	70	Yrs.			03 11	. 34	SC
	land ow		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -f sh	ģ	MD NA		Baltimo	ore				XXYes 2 □ No
	or 28e	Director	10e. Street and Number		20202	10f. Zip Code		10	g. Citizen of What C	ountry?
	1h wit		1743 Waverly Wa	v Apt B		21	239		U.S.	A .
	r dea	Funeral	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Am Black, Wh	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married  **DWidowed 4 ☐ Divorced	1 TXYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		Specify:	Black
5-0036	72 hours after death with the Maryland "naturel", or items 23e or 28e-f show idical Examinatinust be invitibed at	edb	15. Decedent's Educ	ation		dent's Usual Occupa		1	6b. Kind of Business	
215	C 68	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of working ()	g		
21	giene.	E	12th grade	NA		Cook			Hospita.	<u> </u>
힏	be filed within ital Hygiene. Id other than '	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	faiden Surname)	
<u>ya</u>		ပို	Redman Harper				Martha W			
Maryland	12 sho		19a. Informant's Name/Relationship (Tyr		•		and Number or Rural			
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		Wilhelmina Harpe  20a. Method of Disposition			Cnannir  osition (Name of matory or other place	ng Road,		<b>nore</b> Ma loc. Location - City o	21229 Town, State
altimore,	00		Y Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Denation 5 ☐ Other (Specify)	amovarnom State			1		•	Mills, Md
	permit. Pag Department Important: B any injury o	i	21. Signature of Funeral Service License		22	2. Name and Addres	ss of Facility	21/04	Owings	MILIS, MU
ñ	permit. Departm Importa any inju		Afrone a	homas	M Cro	arch F/E	H West ash Ave,	Baltin	more Md	21215
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the						Approximate Interval Between
L	Physician		Immediate Cause (Final disease or condition	munen	dino	-links	rction			Onset and Death
	/Medical		resulting in death)	Due to (or as a con	nsequence of):		9,000			
	Examiner	L	Sequentially list conditions, if any, leading to immediate	to (or as a con	now					
_	ed isit	nine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	WILLIAM OF	nsequence of:	Ol mais	2			
_	ficate be executed physician and is the burial-transit	Examiner	that initiated events cresulting in death) Last	Que to (or as a con	nsequence of):	BUTTE	<u> </u>			
68760	e be e siciar e buria	alE		Hucos	2 into	Olerene	°2			
	ificate g phy as the	edical		1	7 *					
Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use ar	Physiclan/M	23b. was decedent pregnant	3c. If yes, outcome of pr		DEctopic pregnancy			23d. Date of de	
	e deat he att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐ Unknown		Other (specify)	······································		Month	Day Year
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Re	ne lav e has ge 2	Completed						autopsy perform	prior to death?	completion of cause of
ā	iiclen: The certificate rector, pag		25. Was case referred to medical				26. Place of Death	1 Yes 2		s 201 No
$\geq$	ysicle is cer direct	o Be	eveminer?	ospital:	2 ER/Outpatier	nt 3 DOA Oth			nce 6 Other (Spe	ecity)
Division of Vital Records,	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	f 28c. Injury Work	y at 20	3d. Describe ho	w injury occurred	
<u>ত</u>	endir eath. or: Af	satte	2 ☐ Accident investigation				Yes 2 □ No			
Ĕ	l or Attendate after deatl	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)	reet, factory, office	21	Bf. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	pitel ours a erel [		29a. Certifier 1 Certifying Phys	icien: To the best of my	v knowledge dest	h occurred at the time	ne date and place as	nd due to the co	use(s) and manner o	s stated
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical		ner: On the basis of exa and manner stated.						
	To the To the To the complex c	Me	29b. Signature and title of certifier	11/2	11 1	29c. License	e number		d. Date signed (Mon	/ -
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	541		30. Name and address of person who co		(Item 23a) (Type,	Print)	2 2122	7		
			9110 Philodo		a Ya	ew m	) 2123/			
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 9 2004	32. Registrar's S	Dawn Ap.	acto				
	3.0		/							

			1 - For State Registrar	State of Maryla		artment of Heartificate of De			ene 3. No. 200	+ 15955
П	Physici	an	Decedent's Name (First, Middle, Last)  Fig. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.			_		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Eugene	R.	Huff	man, Jr.		May 14,	2004	4:34 p M
	Examir	ier	4a. Facility Name (If not institution, give 1602 Forest Hill  5. Social Security Number 6. Security Number 6	Ave	rs. last birthday)	4b. City, Town, or Lo  Baltimo  If Under 1 Year   If		9. Cate of Birth	4c. County of Dea	
	Funeral Director		216-42-9932	M 2□F 60	Yrs.		Hours Min.	8. Date of Birth (Month, Day, ) OCt. 19	, 1943 Mai	thplace (State or Foreign punity) "YLand
	Maryland f show	o	10a. State 10b. County  Maryland N/A		City, Town or Lo					10d. Inside City Limits 1, ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		Darcinoi	10f. Zip Code		100	g. Citizen of What Co	ountry?
	th with	aiD	1602 Forest Hill A	we.		21230		Ţ	JSA	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Examinational be notified at	by Funeral	11. Marital Status 1 Never Married 2점 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, M I□Yes 2점 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of worki	ng 16	Sb. Kind of Business	•
121	e filed w Il Hygier other th		17. Father's Name (First, Middle, Last)		Ca	b Driver			Self Empl	.oyed
yland	2 should be fi and Mental H is marked of aumatic ever	To Be	Eugene R. Huffmar				Mary A.			
	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (Ty, Shirley A. Huffma	n	1602	ng Address (Street and Forest Hil	1 Ave.,	Baltimor		
Baltimore,	permit. Peges 1 an Depertment of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R	amount from Chata	cemetery, cren	natory or other place)	1		c. Location - City or	
ij	it. Pe intmen intent: injury		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			ark Cemeter  . Name and Address of	-		Baltimore,	
Ba	Deperminant in the perminant	1/2			3620 Wilke	20		Funeral		
	Physician /Medical		23a. Part. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	TATIC	er the mode of dying, so		r respiratory arrest		Approximate Interval Between Onset and Death
E	Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons						
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	(0)						
,8260,	cate be executed physicien and s the burial-transit	icai	resulting in death) Last	Due to (or as a cons	equence of):					
.O. Box 6	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 [	Ectopic pregnancy Other (specify)		an water	23d. Date of deli Month	very Day Year
rds, P	quires that in signed build be det	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the ur	nderlying cause given in	n Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	The law requir te has been si age 2 should	Completed					- Annaharaka	24a. Was an autopsy performed	prior to death?	topsy findings available ompletion of cause of
Vital	ysicien: The lis certificate hadirector, page	BeC	25. Was case referred to medical examiner?			26	. Place of Death	(Check only one)	NO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2LJ N0
of <	Physic this ce al dire	ဥ	1 ☐ Yes 2 X No H		☐ ER/Outpatient	1 3□ DOA Other: 4	4 Nursing Hon	ne 5 Residenc	e 6 Other (Spec	ify)
ion o	ding h. After funer	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 \( \superset \text{Yes}	2  No	28d. Lescribe how	injury occurred	
Division	P Pir te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru. State)	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time, d estigation, in my opinio	date and place, a on, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To the within To the comp	ž	29b. Signature and fille of certifier	Com		29c. License nu		29d.	Date signed (Month	Day, Year)
	5		30. Name and address of person who con	mpleted cause of death (It		Print)		- 0	7/1/2	21332
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig		OO CATOI	V /TVE	- BALT	· MD	21229
	Registr		MAY 1 9 2004	Denesa	0 10	2 V. 1				

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate o	f Health a of Death	and M		giene 2	004	15958
	Physic		1. Decedent's Name (First, Middle, Last)				-		2. Date of De	aath		3. Time of Death
4	/Medi		MELVIN	M. HA	ARRIS				May	15,	2004	10:12 P M
4	Examir	ner	4a. Facility Name (If not institution, give s				n, or Location of			4c. Coun	ty of Death	
L			26366 Minden Avenu 5. Social Security Number 6. Sex		o //m com to as birate do		Crisfie				Somer	
	Funeral Director			(M 2□F	e (In yrs. last birthday 84 Yrs.	Months Day		Min.	8. Date of Bir (Month, Da May 21	y, Year)	9. Birth	place (State or Foreign
			Usual Residence of Decedent		0-1				May ZI	, 1919	Vir	ginia
	nylan how		10a. State 10b. County		10c. City, Town or L							10d. Inside City Limits
	e Ma 3a-1 s	cto	Maryland Somerse			risfield	d					1 ☐ Yes 2√☐ No
	or 2	Director	10e. Street and Number			10f. Zip Code				10g. Citizen of	What Cou	ntry?
	s 23s	ral	26366 Minden Avenu				Crisfie				S.A.	
	ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 XYes 2 1 1		Was Decedent o If Yes, specify Co	of Hispanic Ori ouban, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla	ice - Ameri ack, White,	can Indian, etc.
336	hours after death with the Maryland turet; or Items 23s or 28s-1 show al Espartiner must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	War II	1 ☐ Yes 2 ☒N	io Specity:			Speci	ity: Wh.	ite
9	72 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occ	cupation			16b. Kind of E	Business/In	dustry
21	within 7 ene. than r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life	kind of work don DO NOT use reti	ne during most ired)	t of worki	ng			,
7	filed with Hygiene. Ither than	Con	11		Worke	r				Seafo	od	
Maryland 21215-0036	Id be filed within 72 hours after death with the Marylan ental Hygiene. Kad other than "natural", or items 23a or 28a-1 show ic event, it a Madical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)							Maiden Suma	me)	
$\frac{2}{5}$	2 should by and Ment	2	Molar Harris						Morgan			
Ma	s 1 and 2 should f Health and Men tem 27 is marks other traumatic		19a. Informant's Name/Relationship (Type	•		ng Address (Stre					, State, Zip	Code)
	teal teal		Melvin M. Harris,  20a. Method of Disposition	Jr Soi	20b. Place of Dispo	2 Minden			Crisfje Date	eld, MD 20c. Location	218	
no	ages ant of it: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Salisbur	natory or other p					•	
Baltimore,	permit. Pages 'Department of Important: If ite any injury or ot once.		21. Signature Funeral Service Liceon	01		Name and Add		5/17	/04	Salisbu	iry, i	
ä	permi Depa Impo any ir		Robert H. Brads	haw Tr	/ B:	radshaw 06 W. Ma	& Sons	Fun	eral Ho		01015	7
	32		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	1.0011	the death. Do not en	er the mode of dy	ying, such as o	cardiac o	r respiratory ar	rest,	21817	Approximate
	Physician	i Y	Immediate Cause (Final disease or condition	0	Carcino.			CIL				Interval Between Onset and Death
	/Medical		resulting in death)		a consequence of):	VICE OF	100	CIL	00		-	3 MD;
6	Examiner		Sequentially list conditions.									
	ed sit	line	Sequentially list conditions, if any, leading to immediate sauss. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):							
	xecut and d-tran	Examiner	that initiated events c.	Due to for as	a consequence of):							
8760,	cate be executed ohysician and the burial-transit	a E			2 23.730 400.730 577.							
687	ificate g phys	edicai	d.									47
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome		-				23d. Da	te of delive	·rv
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant at 9☐Unknown		Ectopic pregnant Other (specify)						Day Year
<u>О</u> .	that the de led by the a detached t	hys	9 Unknown									
ທົ	99	þ	Part II. Other significant conditions cont	ributing to death bu	at not resulting in the u	nderlying cause g	oven in Part I.		23e. Did to	bacco use con	tribute to th	e cause of death?
ord	w requir been si	ted							1 □ Y	es 2 No	3 Prob	ably 4 🖸 Onknown
Record	e 2 sl	Completed							24a. Was a autops		Were autor	osy findings available inpletion of cause of
									1 Yes		death? 1 🔲 Yes	2 □ No
Viita		Be	25. Was case referred to medical examiner?	ospital:		0	44		(Check only or			
o	Phys r this aral di	. To	1 Yes 2 No	1 Inpatier 28a. Date of Injury		1 3LI DOA				ence 6 🗆 Oth		)
O	nding Ph th. : After th s funeral	tlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	28c. Inju Wa	ork? ⊡Yes 2.⊡N		od. Describe n	ow injury occur	rea	
Division of	l or Attend after death Director: A	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm, stre				8f. Location (S	treet and Numb	er or Rural	Route Number,
	s after s after al Dire	Certification:	4   Nomicide	building, etc.	. (Specify)				City or Town	n, State)		
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	cian: To the best o	f my knowledge, death	occurred at the t	time, date and	place, ar	nd due to the c	ause(s) and ma	inner as sta	ated.
	the hin 24 the F	ledical	one)	and manner stat	examination and/or invited.	estigation, in my	opinion, death	occurre	d at the time, d	ate and place,	and due to	the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	10		10.0	nse number		2	9d. Date signed	d (Month, L	Day, Year)
	ti		our.	(h)	<u>.                                    </u>		0 /42	114		5/17/	04	
	10		30. Name and address of person who com	pleted cause of de			. +	0.1.	/. Y	ND 218	2n 7	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra		uall sta	11, 3	soll	blug, o	14 d/8	0/	
	Registra		MAY 1 9 2004	Gender	B 4	sould						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M		Depa	rtment of tificate of	Health a		l Hygiei	ne	. 15057
			Decedent's Name (First, Mid	die, Last)			inoaic or	Doain	2. Date	Reg.	NOC UU	3. Time of Death
	Physic /Medi		JOCELUN	Ray	12		H	apaci	Mor	nth I	Day Yea	12:58 PM
	Exami		4a. Facility Name (If not instituti	on, give street and number	7		4b. Çity, Town,	or Location o	of Death	9	4c. County of De	eath
			The Johns	HOPKIAS HO	SfitAl		BA14.	MORE	/			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last I		If Under 1 Year Months Days			of Birth oth, Day, Yea	ar) 9. E	Birthplace (State or Foreign Country)
	Director		215-69-6742	10 M 20 F		Yrs.	1 19		Mar.		2004 Mai	ryland
	and w		Usual Residence of Decedent  10a. State  10b. Coun	ty	10c. City, To	wn or Loc	cation					10d. Inside City Limits
	Mary f sho	ò	Margal Dood Hard	E	71							1 ☐ Yes 2 ☐ No
	the 28a	Director	Maryland Hart 10e. Street and Number	LOIG	AOLI	ngdon	10f. Zip Code			10a.	Citizen of What	Country?
	3a o	0	626 North B	Branch Ct.			21	009			USA	,-
	death	by Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. W			jin? (Specify Yes , Puerto Rican, e	or No-	14. Race - An	merican Indian,
9	after or ite	F	1 ∑tNever Married 2 ☐ Ma	Armed Forces  arned 1 Tes 2 Tes  If Yes, Give	<b>Ž</b> No ,				, Puerto Rican, e	tc.)	Black, Wi	
93	72 hours afler death with the Maryland natural', or items 23a or 28a-f show disal Examinar must be codified at	db	3 ☐ Widowed 4 ☐ Divorce	Year or Dates:			☐ Yes 251 No	Specify:			Specify:	White
21215-0036	natu natu	Completed	15. Decede (Specify only high	ent's Education lest grade completed)	16	(Give k	ent's Usual Occu	during most	of working	16b.	. Kind of Busines	ss/Industry
12	withir ane. than	d E	Elementary/Secondary (0-12)	College (1-4or	5+)		O NOT use retire	9 <i>d)</i>		}		
	filed within Hygiene. Hher than "	င္ပ	17. Father's Name (First, Middle	a. Last)			nfant	18 Mother	r's Name (First, I	Middle Maid	lon Cumomo)	
an	Mental Merked o	m	Dean Andre					Amaı			zdersky	
Maryland	2 should and Men is marke	2	19a. Informant's Name/Relation		19	9b. Mailing	Address (Stree				y or Town, State	Zin Code
Z	and 2:		Dean Andrew Ha								MD 2100	
ē,	es 1 and of Health if item 27 r other tr		20a. Method of Disposition		20b. Place		ition (Name of atory or other pla		Date	-,-	Location - City of	
Ë	Pages nent of I int: If its iry or o		1 Marial 2 ☐ Cremation 1 Donation 5 ☐ Other	n 3 □Removal from State (Specify)			1 Cemete		-18-04	Be.	l Air, M	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples must be notified at once.		21. Signature /f Funeral Service	e Licensee	1	-			Home, F			2
<u>m</u>	89 = 28		Marles	9 mgg	/	113	17 Color	abazar I	Dood Nh	inado	n. Marvl	and 21009
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that cause st only one cause on each	d the death. Do	not ente	r the mode of dy	ing, such as c	cardiac or respira	tory arrest,		Approximate Interval Between
8	Physician		Immediate Cause (Final disease or condition	. CEDS.	5							Onset and Death
	/Medical Examiner	ı	resulting in death)	Due t (or as	s a consequence	e of):						
	Lxammer	L,	Sequentially list conditions,	b. Mid-G	ut V	OLVU	1LUS					20 hours
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence	e of):						70 hours
	and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):	_			_		I WEEKS
8760,	ate be execut <b>e</b> d hysician and the burial-transit	ical E			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/-						
687	death certificate be executed e attending physician and of for use as the burial-transit		N	a.								
Вох	eath certific attending p for use as l	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of de	alivery
	death	icia	in the past 12 months?	4☐Pregnant a	2 Fetal deat t time of death		Ectopic pregnanc Other <i>(specify)</i> _	у			Month	Day Year
P.0	the acht	Physician/Med	9 🗌 Unknown	9□ Unknown								
	es that igned t	by F	Part II. Other significant condit	ions contributing to death t	out not resulting	in the und	dertying cause giv	ven in Part I.	23e	Did tobacco	) use contribute	to the cause of death?
ord	w require been si should t									1 🗌 Yes	2₽No 3□F	Probably 4 Unknown
Vital Records,	e taw i has b	Completed							24a.	Was an autopsy	24b. Were a	autopsy findings available completion of cause of
E H		Col							1 🗆	performed?	death?	
Vit	Physician: Th this certificate al director, pag	Be	25. Was case referred to medic examiner?	al Hospital:			04		of Death Check			
o		- T	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Lampati		Outpatient Time of					6 ☐Other (Spi	ecify)
Ou	ding h. After funer	tlon	1 Natural 5 Pend	ing (Month, Datigation	y Year)	Injury	28c, Injui Wo	rk? Yes 2.∐N		cribe now inj	ury occurred	
Division	Attending r death. sctor: After by the fune	flca	3 Suicide 6 Could		iury - At home, f	arm, stree			-	tion (Street	and Number or F	Rural Route Number,
Ö	taf or Attendii s after death. al Director: A ad in by the fu	Certification;	4  Homicide determ	building, ei	tc. (Specify)		, , , , , , , , , , , , , , , , , , , ,		City	or Town, Sta	te)	istal regio regional
	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in E		29a. Certifier 1 Certifyi	ing Physician: To the best	of my knowledg	ge, death o	occurred at the til	me, date and	place, and due t	o the cause(	s) and manner a	is stated.
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medica one)	Examiner: On the basis of and manner st	of examination a	nd/or inve	stigation, in my o	pinion, death	occurred at the	time, date a	nd place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certific	ar AA			29c. Licens				ate signed (Mon	,
•	0		44				RES-	000		MA	4 15.6	2004
	12		1/2 (1)	who completed cause of c	death (Item 23a)	(Type, Pr	rint)		11 1	, /		
			31. Date filed (Month, Day, Year	400 N. WOI	rar's Signature	est	BAH	MORE	111921 FAX	10 2	1287	
	Sta Registr		MAY 1 9		ar s Signature	Ø .	sports					
	3.0		mili T f			′	,					

		1 - State Registrar  1. Decedent's Name (First, Middle, Last)		ertificate of Death	2. Date of Death	J. No. 2004	3. Time of De
Physic /Medi		Lillian B. Hittle				2004 Year	5:50 a
Exami		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of De-		4c. County of Death	
		Lorien - Bel Air		Bel Air		Harford	
Funeral Director		5. Social Security Number 212-32-9199 6. Sex	7. Age (In yrs. last birthday) M 2004F 95 Yrs.	Months Days Hours Mi		(ear) 9. Birthple Country Mary	ce (State or Fo
2		Usual Residence of Decedent  10a. State 10b. County	10e Ch. T				
ms 23a or 28a-f show	ctor	Md. Harford	d 10c. City, Town or L	oingdon		100	d. Inside City L
23a or 2	al Dire	3504 Back Pointe	Court	10f. Zip Code 21009		Citizen of What Country United State	
Department of Health and Mental Hygiene. Important: or liems 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at angle.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 ∐ Yes 2 No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - American Black, White, etc Specify: Wh	С.
ene. than "natur he Medical	pieted	15. Decedent's Educ (Specify only highest grade	completed) (Give	edent's Usual Occupation e kind of work done during most of w DO NOT use retired)	orking 16	b. Kind of Business/Indu	stry
giene th	E O	8 years	College (1-4or 5+) hom	nemaker		own home	
Mental Hygi arked other atic event, t	To Be (	17. Father's Name (First, Middle, Last) Edgar N. Paul		18. Mother's Na Lucy B	ame (First, Middle, Ma. . Lily	iden Sumame)	
alth and N 27 ie ma or trauma		19a. Informant's Name/Relationship (Type Shirley Chenoweth		ing Address (Street and Number or F Back Pointe Cou	Pural Route Number, C	city or Town, State, Zip Co	ode) 09
t: If item		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Dispo cometery, crei	osition (Name of matory or other place)	Date 200	c. Location - City or Town	, State
Department Important: I any Injury o		'4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License		of Faith Cem. 5/ 2. Name and Address of Facility Schimunek Funer		altimore, Mo Bel Air, Mo	
.U = 6 Q		Busi a. W.	cations that caused the death. Do not ent	610 W. MacPhail	Road, Bel	Air, Md. 2	1014
ysicien and ie burial-transit	i Examiner	Sequentially list sunditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
attending physicien and for use as the burial-transit	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/m5?		□Ectopic pregnancy		23d. Date of delivery Month Da	y Year
T -	hysic	1 ☐ Yes 2 12 No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		North Da	y rear
by the a	0_	Part II. Other significant conditions cont	ributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobaco 1 ☐ Yes	co use contribute to the c	
on signed by the at uld be detached fo	by			45171			
as been signed by the 2 should be detached	by			n510 h	24a. Was an	24b. Were autopsy	findings avail
has been signed by the le 2 should be detached	Completed by	25. Was case referred to medical		n510 h	autopsy performed		findings avail etion of cause
s certificate has been signed by the director, page 2 should be detached	o Be Completed by	25. Was case referred to medical examiner?	ispital: 1   Inpatient 2   FR/Outpatient	Other	autopsy performed 1 Yes 2 ath (Check only one)	? prior to comple death?	etion of cause
n. After this certificate has been signed by the funeral director, page 2 should be detached	To Be Completed by	examiner?  1 Yes 2 16 Ho  27. Man or of Death  1 Natural 5 Pending	espital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 3 DOA Other: 4 Vursing H	autopsy performed 1 Yes 2 ath (Check only one)	prior to comple death? 1 ☐ Yes 2	etion of cause
Jeath. Ior: Alter this certificate has been signed by the the funeral director, page 2 should be detached	To Be Completed by	examiner? 1 Yes 2 Ho  27. Man of Death	28a. Date of Injury 28b. Time of	of 3 DOA Other: 4 vursing H	autopsy performed 1 Yes 2 Dath (Check only one)  tome 5 Residence 28d. Describe how in	prior to comple death?  1 Yes 2  6 Other (Specify)  njury occurred	etion of cause
4 hours after death. Funerei Director: After this certificate has been signed by the saly filled in by the funeral director, page 2 should be detached	Certification; To Be Completed by	examiner?  1 Yes 2 Ho  27. Many of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physical Certifying Physical Certifier 1 Certifying Physical Certifier	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Place of Injury - At home, farm, stre	of 3 DOA Other: 4 of ursing H	autopsy performed 1 Yes 2 1 ath (Check only one)  ath (Check only one)  tome 5 Residence 28d. Describe how in City or Town, St	prior to comple death?  1 Yes 2  6 Other (Specify)  njury occurred  and Number or Rural Roate)	ation of cause
ifter death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached	ledical Certification; To Be Completed by	examiner?  1 Yes 2 Ho  27. Many of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physical Certifying Physical Certifier 1 Certifying Physical Certifier	28a. Date of Injury  28b. Time of Injury  28b. Place of Injury - At home, farm, strebuilding, etc. (Specify)  cian: To the best of my knowledge, death ar: On the basis of examination and/or inv	of 3 DOA Other: 4 ursing F	autopsy performed 1   Yes 2   ath (Check only one)    ath (Check only one)    tome 5   Residence   28d. Describe how in    28f. Location (Street City or Town, St.)    and due to the cause   129d.    29d.	prior to comple death?  1 Yes 2  6 Other (Specify)  njury occurred  and Number or Rural Roare)  a(s) and manner as stated and place, and due to the Date signed (Month, Day,	ation of cause
4 hours after death. Funerei Director: After this certificate has been signed by the saly filled in by the funeral director, page 2 should be detached	Medical Certification; To Be Completed by	examiner? 1	28a. Date of Injury  28b. Time of Injury  28b. Place of Injury - At home, farm, strebuilding, etc. (Specify)  cian: To the best of my knowledge, death ar: On the basis of examination and/or inv	of 3 DOA Other: 4 ursing F	autopsy performed 1   Yes 2   ath (Check only one)    ath (Check only one)    tome 5   Residence   28d. Describe how in    28f. Location (Street City or Town, St.)    and due to the cause   129d.    29d.	prior to complete death?  1 Yes 2  6 Other (Specify)  njury occurred  and Number or Rural Roate)  10(s) and manner as stated and place, and due to the	ation of cause

		For State Registrar	State of M	laryland	d / Depa	artment rtificate	of He	ealth a Death	nd M	ental Hy	giene 2	2004	15959
Physici	an	1. Decedent's Name (First, Middle, La Constance M.	st) Harrison							2. Date of De Month Mau	Day	2004	3. Time of Death 7:45 A M
/Medio		4a. Facility Name (If not institution, giv		7)		4b. City, To	own, or L	ocation of	f Death	mag		ounty of Deeth	
LXamii		Millenium Rehabit	litation (	Center		Ell	icot	t ci	ty			Howard	
Funeral Director		213-10-7074	ex 7. A □ M 2 💢 F	ge (In yrs. la 89	ast birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Da Sept.	th ay, Year) 9,1914	9. Birth Cou Mar	place (State or Foreign ntry) YLAND
land land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation	-						10d. Inside City Limits
Mary -1 sho	to	Maryland	N/A			Balti	more	2					1 X Yes 2 ☐ No
th the or 288	irec	10e. Street and Number				10f. Zip C					10g. Citize	n of What Cou	ntry?
ath wil	ai	5042 Erdman Av						21205				I.S.A.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 Is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Marylast Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 🏋 Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	i? <b>੯</b> No		Was Deceder If Yes, specify 1 ☐ Yes 2 [		panic Orig , Mexican, Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		. Race - Ameri Black, White, pecify: Whi	etc.
2 hour	ted	15. Decedent's E	ducation	·	16a. Dece	dent's Usual	Occupat	tion			16b. Kind	of Business/In	
215 Pin 72	piet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4o	r 5+)		kind of work DO NOT use		<i>iring</i> most	of workir	ng			
21.	Completed	11th Grade				Secret						edit Bu	reau
Maryland 21215-0036 The should be filed within 72 hours aft this and Mental Hygiene. Z7 Is marked other than "natural", or retraumatic event, the Maulcal Exami	To Be	17. Father's Name (First, Middle, Last, William Erlin						Ra	.chae		Barry	1	
Aar 2 sho 2 sho 1 and 1 s m		19a. Informant's Name/Reletionship (		· au l							-	own, State, Zi, 21017	o Code)
e, N 1 and Health em 27 ther t		Mr. Richard B. Ho 20a. Method of Disposition	wuson (							lcamp,		tion - City or T	own, State
ages nt of I		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Special		8 1		sition (Name natory or other Cemet			121/	2004			Maryland
Baltimore, permit. Pages 1 ar Department of Hes Important: If item any injury or othe once.		21. Signature of Funeral Service Lice		1	22	2. Name and	Address	of Facility	Sch		Funer	ial Hom	es
Physician /Medical Examiner	ner	23a. Par . Enter the disease, or corshick, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	aDue to (or a	ed the death line. A func- s a conseques s a conseques	ence of):	er the mode of Cleri	of dying,	c (C	eardiac o	r respiratory a	cular	N Diken	Approximate Interval Between Onser and Death
D. Box 68760, in death certificate be executed the attending physician and had for use as the burial-transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	d	2 🗌 Fetal	ncy death 3	Ectopic preg					230	d. Date of deliv	ery Day Year
P. C	by Phys	9 ☐ Unknown  Part II. Dther significent conditions		but not resu	Iting in the u	nderlying cau	use giver	n in Part I.		23e. Did	tobacco use	contribute to t	the cause of death?
cords w require been sig										10	Yes 2 1	No 3 ☐ Prot	bably 4 Unknown
I Re la The la ate has page 2	Completed									24a. Was auto perfe 1 \( \text{Yes} \)		24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Dther		of Death	(Check only	оле)		
- > 0 D	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of In	tient 2 2	28b. Time o			4 Nur		ne 5 Res		Other (Special	fy)
ding h. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, E	ay Year)	Injury	м 250	c. Injury Work?	at es 2 □ N		.00. 20001120	now injury o	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
or Atten frer deal directors in by the	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of I	njury - At ho etc. (Specify	me, farm, sti	reet, factory,					(Street and N wn, State)	Number or Run	al Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 12 Certifying Pl (Check only one) 2 Medicel Exe	nysicien: To the bes miner: On the basis and manner:	of examinati	vledge, deat ion and/or in	h occurred at vestigation, in	t the time	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and pl	nd manner as s ace, and due t	stated. o the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	m				License		0/			igned (Month,	
6		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print	e Re	iev/	Vack	Roag	1 bal	mer	May (a \$ 2122)
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 9 2004		trar's Signat	ure A	souls	/						,

	1	For State Registrar	State	of Maryla		artment of <i>tificate o</i>			-	giene Reg. No. 2	00%	15960
Physiciar		Decedent's Name (First, Middle  (a)TYLE	, Last) Au/	4	145	THES	_		2, Date of De Month	ath Day	Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution,		·	,,,	4b. City, Town		of Death	MAY	12 4c. Cou	anty of Death	07.01
		THE JUHNS HO				- /	MONE					
Funeral Director		5. Social Security Number 284-52-6157	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birt (Month, Da May 8,	h 7. Year) 1952	9. Birthp Court Oh 1	place (State or Foreign htry)
pg 💌		Usual Residence of Decedent  10a. State 10b. County			ity. Town or Lo	cation						
ith the Marylar or 28a-f show		Maryland Cecil			Lkton	cation						0d. Inside City Limits 1 ☐ Yes 2 No
with the Mar	lirec	10e. Street and Number			LKCOII	10f. Zip Code	9			10g. Citizen	of What Cour	ntry?
s 23a oust b	Tal L	49 Palomino Pla				219				USA		
S III	Dy Pur	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	Armed F	: 2 <b>X</b> No Bive	1	Vas Decedent of f Yes, specify C t □ Yes 2011			cify Yes or No- Rican, etc.)		Race - Americ Black, White, <sup>ecify:</sup> Wh	
72 hou	Completed	15. Decedent (Specify only highes	's Education	<del>(</del> )	16a. Deced	lent's Usual Oct kind of work do	cupation ne durina mas	st of workin	20 1	16b. Kind o	f Business/Inc	
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filled Hygie other ent,	0	17. Father's Name (First, Middle, L	ast)		VOIU	nceer C			(First, Middle,			IIICITC
2 should be filed within and Mental Hygiene is marked other than sumatic event, the March To Do Commit	0	Robert (uk)	Aul	t			Wan	da	(uk)		(uk)	
d 2 should the and Men 7 is marke traumatic		19a. Informant's Name/Relationsh		1	The second	g Address (Stre				-		,
s 1 and f Health item 27 other tr		Thomas W. Holme 20a. Method of Disposition		20b.	Place of Dispo	alomino sition (Name of natory or other p		, ELK	ate		0 2192 on - City or To	
Pages ment of h ant: If its		1  Burial 2  Cremation  4  Donation 5  Other (Sp		n State I		ge Epis		5/17	7/04	Perrym	an, Ma	ryland
permit. Pages 1 and 2 Department of Health a Important: If item 27 it any injury or other tra		21. Signature of Funeral Service L	ai $I$			. Name and Add		. IVIC	Comas I	Tunera	l Home	, P.A.
2 402 8 4		23a. Part1. Enter the disease, or shock, or heart failure. List of	CULLS	caused the dea	th. Do not ente	317 Cok	esbury	Road cardiac of	l, Abino	gdon,	MD 210	09 Approximate
Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition		each line.					,			
/Medical Examiner		resulting in death)	aDue to	o (or as a conse	quence of):	TILL FILL	LUME					3 parys
THE STATE OF	5	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conse	guence of):							
executed in and ial-transit		Cause (Disease or injury that initiated events	G	,								
be executed sician and burial-transit		resulting in death) Last		o (or as a conse	quence of):							
icate be physicial sthe burn			d									
nat the death certifice d by the attending prietached for use as the death certifice.	Idilym	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn	aldeath 3 [	Ectopic pregna					Date of delive Month	ry Day Year
the de	1ysic	1 ☐ Yes 2 ÆNo 9 ☐ Unknown	9☐ Unk	gnant at time of one of the community of	death 5∟	Other (specify)						
es the	Š	Part II. Dther significant conditio	ns contributing to	death but not re	sulting in the ur	nderlying cause	given in Part I			bacco use c		e cause of death?
The law require cate has been signated page 2 should to complete the c	חמומ								24a. Was a		b. Were autor	osy findings available
	5								autop perfor 12 Yes	med? 2 \Bo	death?	npletion of cause of 2850
a ect		25. Was case referred to medical examiner?	Hospital:						(Check only or			
er this	- #	1  Yes 2  No 27. Manner of Death	28a. Date	Inpatient 2 e of Injury nth, Day Year)	ER/Outpatien 28b. Time of	28c. In			ne 5 🗆 Resid 8d. Describe h			)
r Attending Phy ter death. irector: After this by the funeral o	allo	1 Natural 5 Pending 2 Accident investig	ation	nin, Day rear)	Injury		Yes 2□	No				
tal or Attending P s after death.  al Director: After ed in by the funers		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Plac	ce of Injury - At h ding, etc. (Speci	nome, farm, stre fy)	et, factory, office	<b>:</b> 0	2	8f. Location (S City or Tow		mber or Rural	Route Number,
To the Hospital or Attending Plantinia 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification.		29a. Certifier 1 Certifying (Check only one)	g Physician: To the	ne best of my kni basis of examina nner stated.	owledge, death ation and/or inv	occurred at the restigation, in m	time, date an y opinion, dea	id place, a	nd due to the d d at the time, d	ause(s) and late and plac	manner as sta e, and due to	ated. the cause(s)
To the within To the comple		29b. Signature and title of certifier				29c. Lice	nse number		2	29d. Date sig	ned (Month, L	Day, Year)
		> \( \lambda \) \( \lambda	rul.			R	ES-0	00		M	44 13	7024
り		30. Name and address of person v	LE BAN	(S)	500 Nom	Print) UTH WOLF	E STRE	ET	BALI			UTND ZIZEZ
State Registra		31. Date filed (Month, Day, Year)  MAY 1 9 201		Registrar's Sign	ature	parks	,					

Physician was a street or sea as the burial-transit mortant in the mortan Hygiene.  Examiner  Function  Toal 10a.  10a.	ual Residence of Decedent a. State   10b. County	RSING HOME  RSING HOME  7. Age (In yrs. last 85)  10c. City,  IMORE  MILL ROAD  12. Was Decedent Ever in U.S. Armed Forces? 1   Yes. 2 M No If Yes. Give Year or Dates:  College (1-4or 5+)  Lype, Print)  HUSBAND  Removal from State  MOUN  See  Allications that caused the death.	st birthday) Yrs.  Town or Loca PIKES  1. 13. Wa If y 10  16a. Deceder (Give kin ifte. bic HOUSE  YOLLE 19b. Mailing 4730 ace of Disposit metery, crema NT ARAR  22. I	ATRIUM CO	DRE If Under 24 Hrs. Hours Min.  21208 Danic Origin? (Sp. Mexican, Puerto Specify: On ring most of work  8. Mother's Name ANNA d Number or Run DURT - 0	ing C  ecity Yes or No-Rican, etc.)  16  C  e (First, Middle, Ma  al Route Number, C  WINGS MIL  Date 20	4c. County of BALTII BALTII 918  14. Race Black, Specify: WN HOMI	MORE 9. Birthpla Country 100 hat Country - Americar, White, et  DRU State, Zip C 2111 City or Tow	J.S.A. In Indian, ic. WHITE
Disperiment of Health and Mental Hygiene.  10	ual Residence of Decedent  a. State  10b. County  MD  BALT	MILL ROAD  10c. City,  IMORE  MILL ROAD  12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 M No If Yes, Give Year or Dates:  ucation de completed) College (1-4or 5+)  FL  type, Print)  HUSBAND  Removal from State  MOUN  See  Alications that caused the death.	Town or Loca PIKES  1. 13. Was If Y  16a. Deceder (Give kin Infe. DC  HOUSE  YOLLE  19b. Mailing 4730 ace of Disposit metery, crema NT ARAR  22. I	ATRIUM CO	21208 Panic Origin? (Sp. Mexican, Puerto Specify:  On gring most of work  8. Mother's Name  ANNA  d Number or Run  DURT - 01	ecity Yes or No-Rican, etc.)  10g  ecity Yes or No-Rican, etc.)  10g  a (First, Middle, Ma  al Route Number, C  WINGS MIL  Date 20	14. Race Black, Specify:  WN HOM iden Sumame, City or Town, SLS, MD. Ic. Location - C	hat Country  - Americar, White, et  iness/Indu  E  DRU  State, Zip C  2111  City or Tow	NY d. Inside City Limi 1  Yes 2  N  y?  J. S. A. In Indian, Inc. WHITE
Section and Mental Information of Health and Mental Information of Health and Mental Information of Health and Mental Information of Informat	MD BALT.  e. Street and Number  4204 OLD MILFORD  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ediceptify only highest grace  [Specify only highest grace  Elementary/Secondary (0,12)  D. Father's Name (First, Middle, Last)  SAMULA  Da. Informant's Name/Relationship (7  PHILIP ISRAEL / Harried  a. Method of Disposition  1 Naurial 2 Cremation 3 Na  4 Donation 5 Other (Specify  Signature of Funeral Revice Licents  Shock, or heart failure. List only of mediate Cause (Final)	MILL ROAD  12. Was Decedent Ever in U.S. Armed Forces? 1	PIKES  13. Was If Y 15  16a. Deceder (Give Riv Infe. DC HOUSE  YOLLE  19b. Mailing  4730 ace of Disposit metary, crama  NT ARAR  22. If 89	as Decedent of Hisp /es, specify Cuban,  Yes 2 No standard of work done during NoT use retired)  WIFE  Address (Street and ATRIUM COmmon (Name of tory or other place)  AT CEMETE  Name and Address of	panic Origin? (Sp Mexican, Puerto Specify: on on most of work 8. Mother's Name ANNA d Number or Run OURT - O	ing C  ecity Yes or No-Rican, etc.)  16  C  e (First, Middle, Ma  al Route Number, C  WINGS MIL  Date 20	14. Race Black, Specify:  WN HOM! iden Sumame, City or Town, SLLS, MD. Ic. Location - C	hat Countrium  - American t, White, et  - Indian State, Zip C 2111  City or Tow	y?  J.S.A.  In Indian,  In Indian,  In Indian,  ICKERMAN  Code)
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ached for use as the burial-transit  hysician/Medical Examiner  REPERSON	sease or condition sulting in death)	a	Co/0		such as cardiac	or respiratory arres	l,	1:	Approximate nterval Between Onset and Death
y the attending prached for use as t ached for use as t hysician/Med	equentially list conditions, any, leading to immediate use. Enter Underlying acce (Discass of If Jury at initiated events sulting in death) Last	Due to (or as a conseque     Due to (or as a conseque     d			-				
V Ph	FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	death 3□E	ictopic pregnancy Other (s <i>pecify</i> )			23d. Date Mont		/ Day Year
	rt II, Other significant conditions or	ontributing to death but not result	iting in the und	lerlying cause given	in Part I.				cause of death?
ate has						24a. Was an autopsy performe 1 \( \text{Yes} \) 2 \( \text{2} \)	pri	or to comp eath?	sy findings availa pletion of cause
rect cer	i. Was case referred to medical examiner? 1 ☐ Yes 2 🚰No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3 DOA Other:		h (Check only one) me 5 Aesiden	ce 6 □Other	r (Specify)	-,1
Afte Tune	Manner of Death  1 Matural 5 ☐ Pending investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work?  M 1 \( \text{Yes}	ıt	28d. Describe how	injury occurred	d	
in b	3 Suicide 6 Could not be determined	building, etc. (Specify)				28f. Location (Stre City or Town,	State)		
within 24 hours at To the Funeral I completely filled  Medical Ce		ysician: To the best of my know liner: On the basis of examination and manner stated.							
<b>N</b> 29b	9b. Signature and title of certifier	` ~	$\bigcirc$	29c. License n	number 37573		Date signed		ay, Year) 2004
h 30.		$\wedge$		V	1 44		VINT	1 11	2001

			State of Maryland / Department of Health and N  1 - State of Maryland / Department of Health and N  Registrar AMFND TIFM #27 PER PHY (231 5/19/0/Centificate of Death		iene 2004	15962
	Physici		1. Decedent's Name (First, Middle, Last)  THEODORE  A  JENKINS	2. Date of Death Month	Day Yeer 3, 2004	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town. or Location of Death  AVE.  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24 Hrs.	R. Date of Birth	4c. County of Death	olece (State or Foreign
	Funeral Director		2/2-58-7234 10 M 2 F 5/ Yrs. Months Days Hours Min.  Usuel Residence of Decedent	8. Date of Birth (Month, Day, SUNE 18	Year) 3,1952 MAA	olece (State or Foreign ntry)
	a-f ehow	ctor	10a. State 10b. County 10c. City, Town or Location BALTIMORE CIT	7		1 No 2 No
	th with the 23a or 28 ast be no	al Director	10e. Street and Number  37/3 WOODHAVEN AVE. 2/2/6		Og. Citizen of What Cou	
920	72 hours after death with the Maryland neturel', or Itama 23a or 28a-f ehow ideal Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0036	filed within 72 ho Hygiene. ther then "netur int, the Wedfoll	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  YEARS  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  LABORER	ing	16b. Kind of Business/In	
Maryland 2	should be filed ind Mental Hygi i marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last)  ROOSEVELT  50NES  18. Mother's Nam  MARY		JEN	IKINS
altimore, Mary	s 1 and 2 sho of Health and item 27 is m other traum		19a. Informant's Name/Relationship (Type, Print)  RONALD SONES (BRATHER)  19b. Mailing Address (Street and Number or Rur  19b. Mailing Address (Street and Number or Rur  19b. Mailing Address (Street and Number or Rur  20a. Method of Disposition  1 Burial 2 Screenation 3 Removal from State  4 Donation 5 Other (Specify)  19b. Mailing Address (Street and Number or Rur  20b. Place of Disposition (Name of cemetery, crematory or other place)  METRO CREMATERY  05-3	BALTIII Date 2	MORE, MD 20c. Location - City or To	own, Stete
Baltin	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee  La Mark N. Williams 2140 N. Putter Art	N 5R.1	FUNERAL	HOME
760,	Physician /Medical Examiner pe prijelitausit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due . (or as a consequence of):			Inierval Between Onset and Death
.O. Box 68	death certifica e attending ph id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliv Month	ery Day Year
0	ures that the signed by Id be detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cardio wo pathy.		acco use contribute to t	he cause of death?
I Records,	ician: The law requires that the certificate has teen signed by the rector, page a should be detache	Completed by	Hypertension. Ho Thoraie Aneurysun	penom	y prior to co ned? death?	opsy findings available impletion of cause of
ion of Vital	ng Phys fter this neral dii	To Be	examiner?	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 Other (Specia	<b>(y</b> )
Division	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
	n 24 hours n 24 hours ne Funera	edical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated.			
	To t withi To tl	Z	29b. Signature and title of certifier  D 00 526 28		9d. Date signed (Month, $5 - 18 - 2$	
	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAREK SALKINI 7600 OSLER DR. 203, TOWSON	MO.	21204	
v	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 9 2004  32. Registrar's Signature  Apocks			

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 15963 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2004 Year **Physician** 16, 8:10 PM May Laura W. Jenkins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 334 Colony Point Place Edgewater

If Under 1 Year If Under 24 Hrs. Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** Hours Months Days 1 □ M 2 🛛 F 03-11-1924 Montana Director 578-36-3644 80 Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or items 23a or 28a-f show Exeminer must be notified at 1 Yes 2 No Director Maryland Anne Arundel Edgewater the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 334 Colony Point Place 21037 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 XXWidowed 4 Divorced Year or Dates: "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th than College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be of Health and Mental item 27 is marked or r other traumatic eve Mental Frank C. Walker Hallie Boucher 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stealey J. Ashley/ Daughter 3305 Leritz Lane, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition i i 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Importent: If any injury or once. Gate of Heaven Cem. 5-20-04 Hawthorne, NY 22. Name and Address of Facility George P. Kalas Funeral Home 21. Sign y of Funeral Service Licen 2973 Solomons Island Rd., Edgewater, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - deseric **Physician** ON resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to infine ridate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month Day Year ō 5 Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X45 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has 1 Yes 2 0 NO or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Division 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - A. home, farm, street, factory, office building, etc. (Sp + y'y)28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerei mpletely filled 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of partifier 29c. License numbe 29d. Date sigped (Month, Day, Year) lu 30. Name and a dress of per on who completed cause of death (Item 23a) (Type, Print) all, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

			1 - State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>	ealth and M Death		giene 2 () . Reg. No.	04 15964
			Decedent's Name (First, Middle, Last)	-				2. Date of Dea	ath	3. Time of Death
	Physici /Medic		James Llewellyn Ke	ennedy, Jr	^			May 15	2004	10:10 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of	
			123-C Versailles (		(In yrs. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	0 D-1( Did	Baltir	
	Funeral Director			144 00 =	34 Yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan. 10	Year) 920	9. Birthplace (State or Foreign Country) Maryland
	ס		Usual Residence of Decedent					ouns 10	, 1320	
	arylan show	L	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	be Milie	Director	MD Baltimore		Towson	1				
	death with the Maryland ms 23a or 28a-f show rmust be notified at	i Di	123-C Versailles (	Circle		10f. Zip Code 21204			10g. Citizen of W USA	nat Country?
		Funeral	11. Marital Status 1 □ Never Married 2 🔀 Married	12. Was Decedent E Armed Forces? 1 XYes 2 N	0	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spanic Origin)	ecity Yes or No- Rican, etc.)	14. Race Black	- American Indian, , White, etc.
2-0030	72 hours after natural', or ite dical Exemine	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	60	1 ☐ Yes 2 ☒No	Specify:		Specify: 16b. Kind of Bus	
C17	within 72 ene. than na	Completed	(Specify only highest grade	College (1-4or 5-	F) !	dent's Usual Occupa kind of work done of DO NOT use retired,				•
N	Hygi ther	e Co	17. Father's Name (First, Middle, Last)		CIVIII	an Persor	18. Mother's Name			nt of The Army
yland	e d d o	To Be	James L. Kennedy,	Sr.				arvev		,
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty			ng Address (Street a				
e, S	교문 등 후		Dorothy M. Kennedy	/ / wife		Versaill		; Towso		
	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20028.		20a. Method of Disposition 1 → Burial 2 → Cemation 3 → R	emoval from State	20b. Place of Dispo cemetery, crer					City or Town, State
Saltimor	iit. Pa artmer ortant injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Ucense</li> </ul>	99 (1)		ark Cemeto 2. Name and Addres	and the second s	/04	Baltimor	e MD Ork Road
ď	Depa Impo any ir		) (20).	- Chy		uck Towson		Home		, MD 21204
	1		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	3.6	ORONAI				ASE	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
Š	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):					
2/00	cate by	dicai								
X	certific iding p		IF FEMALE:	3c. If yes, outcome of	of pregnancy				22d Date	of delivery
ecords, P.O. box to	<ul> <li>requires that the death certific</li> <li>been signed by the attending p</li> <li>should be detached for use as</li> </ul>	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth — 2 4 ☐ Pregnant at t 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mont	
	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to						oute to the cause of death?	
cords,	quires en sign uld be	ed b	CHROME 1		FAILUR	(e		1 □ Y	es 2□No 3	B ☐ Probably 4
eco	e 2 sh	Completed	HYDERTE	en Sian				24a. Was a	sv pr	ere autopsy findings available ior to completion of cause of eath?
Igal	sician: The law secrificate has b lirector, page 2 s		25.14					perfor 1 ☐ Yes	2 No 1 [	Yes 2□ No
>	sicia s certificación	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ➡No	lospital: 1 🗌 Inpatier	nt 2 ER/Outpatier	nt 3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hor			(Specify)
101	ding Physician: h. After this certific funerat director,		27. Manner of Death	28a. Date of Injun (Month, Day	28b. Time of		at 2		ow injury occurre	
200	endin sath. or: Aft he fur	atio	1 Natural 5 Pending 2 Accident investigation	(INGINI), Day	/ dai/ injury		res 2 □No			
DIVISION	i or Attence after death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, str . (Specify)	eet, factory, office	1	28f. Location (S City or Town	treet and Number n, State)	r or Rural Route Number.
	To the Hospital or Attending Physidan: within 24 hours after death. To the Funeral Director: Atter this certifica completely filled in by the funeral director, is	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ner: On the basis of	f my knowledge, death	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the c ed at the time, d	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)
	o the vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stat	.ou.	29c. License	number	2	9d. Date signed	(Month, Day, Year)
	Y		Novem M	Mary	- M.D	D	23319		MAY 1	7 2004
	13,		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)  OQ(U=	706	sen 1	no 2	11204
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ath (Item 23a) (Type,	<i>M</i> •				
	Registr	ar	MAY 1 0 2004	Molene	, It for	ME				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2014 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Α. John Kasper May 16, 2004 2:05 4c. County of Death
Prince George's 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

Temple Hills

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | 8/18/19/51

9. Birthplace (State or Foreign Country) Massachusetts

Black, White, etc.

Month

29d. Date signed (Month, Day, Year)

May 16, 2004

111 Penn Street, Baltimore, Maryland 21201

Day

3 Probably 4 □Unknown

Year

At scene

Temple tills MD

10d. Inside City Limits

Onset and Death

1 ☐ Yes 2 No

**Physician** /Medical Examiner

1 - For State Registrar

4603 Weldon Drive

10b. County

Maryland Prince George

5. Social Security Number

549-76-0390

Usuel Residence of Decedent

**Funeral** Director

or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural: ~!- any injury or other traumatic event.

Priysician /Medical Examiner

Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transi P.O. Box 68760, use as the Division of Vital Records, funeral director, page 2 should Certification: To this after death Diractor: filled in by

Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 4603 Weldon Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Antique Dealer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John C. Kasper Dolores Flack Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John C. Kasper/Father 4603 Weldon Drive Temple Hills, MD. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Kalas Crematory 5/20/04 \* 4 ☐ Donation 5 Other (Specify) Edgewater, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of FacilityGeo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 alus at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1 Enter the disease or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) multiple blunt and sharp force infines and Thermal injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physiclan/Medical Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 XNo 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 2-Yes 2 □ No autopsy performed? ſ**X** Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury

North, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2X No investigation AM 2 Accident 28e. lace of Injury - At home, farm, street, factory, office building, etc. (Specify) subject assaulted 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4603 Weldon Dr. Temple Hills 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

7. Age (In yrs. last birthday) 52 yrs

10c. City, Town or Location

Temole Hills

1**X** M 2□ F

Registrar DHMH 17 Rev 1/2001

within 24 hours a

Medical

29b. Signature and title of certifier

Idsha

31. Date filed (Month, Day, Year)

70460

2004 9

THE

White

32. Registrar's Signature

nher

30. Name and address of person who completed cause of death (kem 23a) (Type, Print)

29c. License number

O.C.M.E.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

			1 - For State Registrar	State of Maryland	d / Departmer <i>Certificat</i>	it of Health and e of Death	Mental Hy	giene 2001 Reg. No.	+ 15966
	Physicia	an	1. Decedent's Name (First, Middle, Last)	V ala P			2. Date of De Month	Day Year	3. Time of Death
1	/Medic	al	Kenneth Francis  4a. Facility Name (If not institution, give strp		4b, City,	Town, or Location of De	ath May	4c. County of Dear	1
	Examin	eı	Franklin Square H	ospital len	TEV ROS	CAR If Under 24 H	rs. 8. Date of Bir	Baltimor	hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 19-58-5270	7. Age (In yrs. I	Yrs. If Unde Months		n. Sept.	22,1953 Ma	ryland
			Usual Residence of Decedent  10a, State 10b, County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Maryli a-f sho	tor	Maryland Baltimore		Balti	more			1 □Yes 2 No
	with the	Director	10e. Street and Number 4219 Blakely Aven	1110	10f. Zi	21236		10g. Citizen of What Co	
	death death ms 230	neral		. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dece	dent of Hispanic Origin? orfy Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		erican Indian,
36	hours after death with the Maryland tural', or Items 23a or 28a-f show I Examiner must be rediffed at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes				Vhite
5-0036	72 hou natura dical E	eted	15. Decedent's Educal (Specify only highest grade of	tion completed)	16a. Decedent's Usu (Give kind of w	al Occupation ork done during most of v use retired)	vorking	16b. Kind of Business Internation	Industry ral Union of
7	filed within 72 Hygiene. other than "nai ent, the Medic	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)	Operating			Operating 1	
7C nd 2	be filed within 72 ho ital Hygiene. id other than "natui event, I. e Medical	Be C	17. Father's Name (First, Middle, Last)			18. Mother's N	(	o, Maiden Surname)	
ly Sa	2 should be and Mental I is marked o	2	Kenneth L. Kahl  19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing Addres	s (Street and Number or			Zip Code)
, N & S	od 2 lih e 27 is			(wife)	_	kely Avenue	, Baltimo	ore, MD 212.	
7 -	0 0		20a. Method of Disposition  1	moval from State	Place of Disposition (Na cometery, crematory or Undens of Fo			Baltimore,	
Oh   Baltimor	permit. Pages Department of Important: If it any injury or o	ĺ	21. Signature of Funeral Service Licensee		22. Name a	nd Address of Facility	Schimunek	Funeral Ho	mes
	80588	H	23a. Part1. Enter the disease, or complica	ations that caused the deat		Belair Kd., de of dying, such as card			Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Cancer of	Heluna				Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):				,
	p =	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	queлсе of).				
-	axecute	Examiner	Cause (Disease of injury that initiated events c. resulting in death) Last	Due to (or as a conseq	quence of):				
8760,	rcate be executed physician and sthe burial-transit	dicall	d.						
Box 6	eath certific attending p	n/Med	IF FEMALE: 236. Was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ancy al death 3 □Ectopic	orogo angy	-	23d. Date of de	
P.O. B	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of c				Month	Day Year
	res that the de signed by the a i be detached f	by Ph	Part II. Other significant conditions control		sulting in the underlying	cause given in Part I.		tobacco use contribute t	
ord	w require been sign	eted	Cerebrovascular	ucciunt			24a. Wa		robably 4 Unknown
√ Vital Records,	The law te has b age 2 s	Completed					auto	formed death?	
19 ja	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	ospital:		Othor	Death Check on		
	g Physi er this c eral dir	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 C 28b. Time of Injury	28c. Injury at Work?		sidence 6 Other (Sp. how injury occurred	ecify)
Division of	tending leath. Ior: Aft the fun	catlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 Tes 2 No	28f Location	(Street and Number or F	Rural Route Number
Divi	al or At a after d Il Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	ory, office	City or To	own, State)	aran nodio nomo on
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying Physi (Check only one)	ician: To the best of my kni er: On the basis of examinating and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and pl on, in my opinion, death o	ace, and due to the ccurred at the time	e cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
_	To the within 2 To the comple	Med	29b. Signature and title of certifier	and mainler stated.	2	9c. License number		29d. Date signed (Mor	/
	1		1 My			D18	486	5/16/ sedale, M	04
	19.1		Dr. Sylvia Morr		an Z3a) (Type, Print)	quare Dr	ive Ro	sedale, M	d. 21237
	St Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature				

DHMH 17 Rev 1/2001

ORIGINAL

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once. Kalendek, Danie

State Registral

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

Physician /Medica Examine

ending physician and use as the burial-transit The law requires that the death certificate be executed detached Hospital or Attending Physician:

Vital

Vithin 24 hours after death.

To the Funeral Director: A

Medical Certification; To Be Completed by Physician/Medical Examiner

 Birthplace (State or Foreign Country) 5. Social Security Number 216-24-6543 Usual Residence of Decedent 10a. State 10d. Inside City Limits 1 Yes 2 No Directo Maryland 10e. Street and Number 8 Juliet Lane, 11. Marital Status 1 ☐ Never Married 2 X Married þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Locke Insulator Shipping Foreman 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Kalendek Anna Jagielska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elena Kalendek (wife) 8 Juliet Lane, Unit 104, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Mary! 5/20/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licen ea 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsi Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underspring Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform Ca Sar 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ☐ ER/Outpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d, Date signed (Month, Dav. Year) 29b. Signature and title of gertifier 29c. License number D005772 aure 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore, MD 21237 stee

Dr. Laura = 31. Date filed (Month, Day, Year)

MAY 1 9 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Las **Physician** 2001 omah Olal /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Nov 9 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F 82 174-14-1259 Yrs PĂ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or tiems 23a or 28a-f show eny njury or other traumatic event, the M. digal Examinating Examinating at once. PA Canonsburg Washington 1 X Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15317 USA 137 E. Pike Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Montgomery Wards Elementary/Secondary (0-12) financial agent 1218. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Frank Matvuf Julia Gula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia A. Lochran (daughter) 1006 Courtland Dr., Eldersburg, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5-18-04 1 XBurial 2 ☐ Cremation 3 X Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oak Spring Cemetery Canonsburg, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Page Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and P.O. Box 68760. physicien IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 □ Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 🔲 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title o certifie 29d. Date signed (Month, Day, Year) Oj cause of death (Item 23a) (Type, Print) 30. Name and no complet 200 MEMORIAL WESTMINSTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 1 9 2004

210	9		For State Registrar	State of Ma	aryland /	Departm <i>Certific</i>			nd Mental Hy	ygiene Rag. No.	0001	15969
	Physici		1. Decedent's Name (First, Middle, Las Virgil Myrc		ener				2. Date of D Month May		y Year	3. Time of Death
>	/Medic Examir	3	4a. Facility Name (If not institution, give Woods behind route 1 a		enue	4b. 0	City, Town, or	Location of	Death	4c.	County of Deat Howard	
	Funeral Director		230 32 2113	ex 7. Ag M 2□F	e (In yrs. last b 48	Yrs. If Ur Mont	hs Days	If Under 24 Hours	Min. 8. Date of B (Month, D April	13,	9. Birt 1956 W	hplace (State or Foreign untry) est Virginia
	Maryland s-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince	George's	10c. City, To	wn or Location						10d. Inside City Limits  ty Yes 2 □ No
	with the	il Directo	10e. Street and Number 114 LaFayette Ave	•		10f.	Zip Code 2070	<b>)</b> 7		10g. Cit	izen of What Co	untry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "naturel", or Itams 23a or 28e-1 show other traumatic event, the Medical Example must be notified at	by Funeral	11. Marital Status  17 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:			ecedent of Hi specify Cuba s 21 No	ispanic Origin, Mexican, i	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Ame Black, White	
Maryland 21215-0036	within 72 ho iene. than "natur the Medical I	Completed	15. Decedent's Ec (Specify onfy highest gra Elementary/Secondary (0-12)			a. Decedent's l (Give kind of life. DO NO Labor	f work done o T use retired	durina most o	f working		ind of Business/	·
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	and 2 sho ealth and I m 27 Is ma	9 3	19a. Informant's Name/Relationship (19a. Informationship (19a. Infor			P.O. B	ox 308		or Rural Route Num. ackville, Date	WV 2	6559	
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of Vital	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		Outpatient 3	DOA Othe	er: 4 ☐ Nurs	f Death (Check only ing Home 5 Res 28d. Describe	sidence		cify) At scene
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	/		30. Name and address of person who		leath (Item 23a				Baltimore			
10	St. Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 9 20		ar's Signature	b 1	books					

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	land ow		10a. State 10b. County	7.7.	10c. City, Town or L	ocation						10d. Inside City Limits
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	r 28s	Director	10e. Street and Number			10f. 2	Zip Code			10g. Ci	tizen of What Co	ountry?
	th wit		6116 Belair Road	l			212				USA	Α
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or teme 23a or 28a-f show event, It a Medical Eracinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  **XX**Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2√21 If Yes, Give Year or Dates:	Ever in U.S. 13.			spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or N into Rican, etc.)	0-	14. Race - Ame Black, Whit	
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	of Health Item 27 other tr		20a. Method of Disposition	, (5011)	20h. Place of Disc	osition /	lame of	1	Date Date		ocation - City or	Town, State
altimore,	00-		1 XX urial 2 □ Cremation 3 □ 1  □ Donation 5 □ Other (Specif	Removal from State  ()	Woodlawn	Ceme	etery	5/1	13/04	Bal	lto,MD	
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	<u></u> 'J		PAMKAS KIA	ETERPAL	201-10	9	ISALl	L RIV	ER N	LECT	IC RD.	21221 BALTIMERE
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	Physic /Medi		1. Decedent's Name (F Thomas F.								2. Date of D Month MAY	eath Day 14	, 2002	£	Time of Death 7:33a M
	Exami	ner	4a. Facility Name (If no 320 FERNDA 5. Social Security Number	LE ROAD			. last birthday)	If Under 1 Y	BURNIE		8. Date of Bi	ANI	VE ARU	INDEL	State or Foreign
	Director	ı	142-74-125 Usual Residence of De	0	7. M 2□F	34	Yrs.	Months Da	ays Hours	Min.	8. Date of Bi (Month, D Dec. 18	ay, Ye <i>ar)</i> 8,196	9	Country) N.	State or Foreign
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	with the 3e or 28e	Il Director	10e. Street and Numbe					10f. Zip Coo	19026			10g. Citiz	en of What O	Country?	
980	72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show dical Exaction roust be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4	ZEI Married	2. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	<sup>⊔</sup> 1°2/8	188 <b>-</b> 13. 1	Was Decedent f Yes, specify 0 1 ☐ Yes 2 🗓	of Hispanic ( Cuban, Mexic		ecify Yes or No Rican, etc.)	}	4. Race - An Black, Wh		
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Baltimore,			20a. Method of Disposit 1 ☐ Burial 2 🛣 C 4 ☐ Donation 5 ☐	remation 3 X R	enroval from Sta	ite (	Place of Dispo cemetery, cren	sition (Name or natory or other is & Co	place)		Date	20c. Loca	ation - City o	r Town, S	
Balti	permit. Page Department of Important: If eny injury or once.		Signal re of Fur		MOT		7	Name and Ad 221 Gr	dress of Fac	iliy Har n Dr	man F	uner tean	al Se Gler	ryi Bui	ce P.A.
-	Physician /Medical		23a Part . Enter the d shock, or hear fa Immediate Cause (Fina disease or condition resulting in death)	liuge. List only on	e cause on eacr	hple	h. Do not ente	er the mode of	dying, such a	s cardiac d	or respiratory a	rrest,		Appro	oximate val Between t and Death
68760,	tificate be executed  by physician and as the burial-transit	al Examiner	Sequentially list condition any learning to minimacause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	diate dig		as a conseq									
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of Vi	Physic r this ce ral direc	To B	examiner? 1 X Yes 2 □ No  27. Manner of Death	-	spital: 1  Inpa		ER/Outpatient	3 DOA	Other: 4 N	ursing Hon	(Check only one 5 Resid	dence 6		ecify) SC	ENE
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	1		30. Name and address of Tasha Z	-Green	heng	M.D	1.	rint) 11 Penn	Stree	et, Ba	ltimor	e, Ma	ryland	212	01
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			1 - For State Registrar	State of Maryland /	Department of Certificate of	Health and M	Mental Hygie	_	+ 15972
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last)     Merle Lynch     A. Facility Name (If not institution, give s	treet and number)	4b. City, Town	, or Location of Death	-	Day Year 2004 4c. County of Deal	3. Time of Death
	Funeral Director	lei	3605 Frankford Av 5. Social Security Number 6. Sex 213-01-1976			Baltimo		N/A ear) 9. Birt	hplace (State or Foreign untry) cyland
	death with the Maryland ms 23a or 28a-f show rmat be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD N/A  10e. Street and Number	10c. City, To	wn or Location Ball	timore	10g	. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?
020	a within 72 hours after death with the Marylar jene. r than "naturel", or Items 23a or 28a-1 ahow The Medical Examiner must be rivilled at	by Funeral	3605 Frankford Av  11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	enue  Was Decedent Ever in U.S. Armed Forces?  1 🕅 Yes 2 □ №6-16-4 If Yes, Give Year or Dates: 8-12-45	l 1□Yes 2Ñ∧	21214 of Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	United  14. Race - Ame Black, Whit  Specify:	rican Indian,
0500-61717	a filed within 72 ho Il Hygiene. other than "natur rent, Ir a Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)	ation 16 completed) 16 College (1-4or 5+)	Sa. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	ne during most of work ired) ident	king	hesapeake Affil	and
Maryland	2 should be and Mental is marked c	To Be	Irwin Lynch 19a. Informant's Name/Relationship (Type		9b. Mailing Address (Stre	Gladys	Reddish	ity or Town, State, 2	Tip Code)
pailimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tt	(	20a. Method of Disposition  14 Burial 2 Cremation 3 R  Donation 5 Other (Specify)  21. St. natury 1 Funeral S	20b. Place cemet	of Disposition (Name of tery, crematory or other park Cemet 22. Name and Ado	olace)	7-2004 B brose Fun	altimore, eral Home	MD , Inc.
)  -  -	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	o not enter the mode of d	ying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
,007	e be executed /sician and e burial-transit	cal Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
O. DOX OG	at the death certificat by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnar 5 Other (specify)			23d. Date of deli Month	very Day Year
necolds, r	The law requires that the tee bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	ributing to death but not resulting	_ ^ _	given in Part I.	1 ☐ Yes	co use contribute to	the cause of death?
Vilai Rec		Be Completed	25. Was case referred to medical examiner?			26. Place of Deat	24a. Was an autopsy performed 1 Yes 2 An (Check only one)	prior to death?	copsy findings available ompletion of cause of
	Phys this al dii	Certification; To	1 Yes 2 No  27. Manner of Leath 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Year)	Time of 28c. In Injury M 1	ury at ork? ☐ Yes 2 ☐ No	me 5 X Residence 28 describe how i	njury occurred	
2	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical Certif	4 Homicide determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home, building, etc. (Specify)  cian: To the best of my knowled;  pr: On the basis of examination a add manner stated.	00. death occurred at the	time date and place	28f. Location (Stree City or Town, S and due to the caus red at the time, date	tate)	stated
,	To the within to To the comple	Med	29b. Signature and title of certifier  30. Name and address of person who co	Canes ma	29c. Lice	3895		Date signed (Month	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2004	32. Registrar's Signature	5820	YORKE	0#23, 1	BAZTIMO	Rt, no

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Me State  State Registrar  State Certificate of Death	ental Hyg	•	15973
1				2. Date of Deat		3. Time of Death
	Physic /Medi	cal	Stanley Ieroy Laye, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	May	Day Year 14, 2004  4c. County of Death	6:35AM
	Exami	ner		oce	Harfo	ad.
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
	Director		1VIM 2DF   Months Days Hours Min.	(Month, Day,		yland
	p.		Usual Residence of Decedent		•	
	anylar show	پ ا	10a. State 10b. County 10c. City, Town or Location		1	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	88-f	ecto	Maryland Harford Churchville			
	with ti	- E	106. Street and Number 101. Zip Code 21028		0g. Citizen of What Cour USA	ntry?
	DEALLITIOTE, IMETYIGITIES A LETS-CUSSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumetic event, the Midical Examinar must be notified at ance.	Funeral Director			14. Race - Americ	can Indian.
,,	r Iten	臣	A,med Forces? If Yes, specify Cuban, Mexican, Puerto R 1 □ Never Married 2 □ Married 14 ⊇ Yes 2 □ No	lican, etc.)	Black, White,	
200	oli, o		3X Widowed 4 □ Divorced If Yes, Give Year or Dates: 1943-46 1 □ Yes 2X No Specify:		Specify: Wh	ite
<u> </u>	P 72 hc	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	a	16b. Kind of Business/In	dustry
5	T ight	idu	Elementary/Secondary (0-12) College (1-4or 5+) Most inc. Incharge		I C Corres	
Ċ	Hygie nt. mt.	S	12 PROVING TRISPECTOR  17. Father's Name (First, Middle, Last)  18. Mother's Name (		U.S. Governi	ment
ž	at the find the control of the contr	Be	Dondalah Basilania T			
Ī	ir y in thouse and Me mark metic	2	Randolph Frederick Laye <u>Lenora</u> 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural)	(uk) Boute Number	Fadeley City or Town State Zin	Code)
2	INICA Dd 2 s Ilth ar 27 is r treu		John H. Laye - Son 3612 Aldino Road, Churc			
9	s 1 ar		20a. Method of Disposition 20b. Place of Disposition (Name of Da		20c. Location - City or To	
6	Page ento nt: ff		1 ☑ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Harford Mem. Grdns. 5/17/0			
Action of the Manufacture of the Child	mit. I partm porter / inju	1	richter Field. Grans. 13/11/10		Aberdoon, M Funeral Hor	
à	Departimbos		flathy a Decepte 1317 Cokesbury Road	l. Abino	odon. Marvla	and 21009
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arre	est,	Approximate Interval Between
	Physician	10	Immediate Cause (Final disease or condition a. CHRONIC RENAL FAILURE			Onset and Death
$\sim$	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b.			
id	ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
6	executed n and ial-transit	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
760	ate be executed sysician and he burial-transit	cal E				
703	ficate ficate physics the		d.			
2	hat the death certifica od by the attending phydelached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	эгу
3	death death d for	icia	in the past 12 months?  1		Month	Day Year
, (	by the tache	hys	9 ☐ Unknown 9 ☐ Unknown			
7	res tha igned be dei	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to the	ne cause of death?
7	law requires as been sign 2 should be	ted	CONGESTIVE HEART FAILURE	1 🗆 Ye	os 2 No 3 □ Prob	ably 4 Unknown
Stanley of Vital Boords	The law requires that the death certifica the law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as it	Completed	DIABETES MELLITUS	24a. Was as		psy findings available mpletion of cause of
2	The The	Con		perform	ned? death? 2DZNo 1 ☐ Yes	2 No
tan ley	Or Vital ner Physicien: The lav r this certificate has ral director, page 2	Be (	25. Was case referred to medical examiner? 26. Place of Death /			- / 3
55	Physi Physi this c	2			nce 6 Other (Specify	y)
	Jing I	ion	1 Matural 5 □ Pending (Month, Day Year) Injury Work?	id. Describe no	w injury occurred	
	Attending r death. sctor: After by the fune	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	If. Location (St	reet and Number or Rura	i Route Number.
9 8	after Direct dinby	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town	, State)	
Loye	To the Hospital or Attending Physicien: The Within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only (Ch	d due to the ca	tuse(s) and manner as st	ated.
-3	n 24 l n 24 l ne Fu	Medicai	(Check only one)  Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	f at the time, da	ate and place, and due to	the cause(s)
	To th To th	Σ	29b. Signature and title of confiler 29c. License number		9d. Date signed (Month,	Day, Year)
	VI	1	30. Name and ad person when person where person w		5/14/04	
	12.71		30. Name and ad person pleted cause of death (Item 23a) (Type, Print)			
	•	1	SURESH DHANJANI, HD 6225. UNION AVE, HdG, 31. Date filed (Month, Day, Year)  32. Registrar's Signature	MDZ	1078	
	St Regist	ate rar	St. Date filed (World, Day, Teal)			
			MAY 1 8 2004 Section & Sparke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 10e 19b per FH G832.06/09/04dhb

State of Maryland 7 Department of Health and Mental Hygiene 2000 State Registra #17 PER FH C831 5/19/04 JEC ertificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LEBERMAN MELVIN Ι. nas 15,2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE FRANKLIN JOUARE HOSPITAL KOSEDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUNE 24, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F 216-16-9380 77 Yrs. MD Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits other traumatic event, the Madical Exercit at must be rightled at 1 ☐ Yes 2 🙀 No Director BALTIMORE PARKVILLE 10e, Street and Number 9509 Fuller Avenue 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 9507 FULLER AVENUE 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: 1 ☐ Yes 2 X No WHITE þ Specify: 3 ₩ Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If itam 271s marked other than "na any injury or other traumatic event, Ita Madic once. Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR CONSTRUCTION HOME BUILDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) KARE KARI, LERERMAN LEBERMAN KROOPNICK JENNIE 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9507 FULLER AVENUE - PARKVILLE, MD 21234 19a. Informant's Name/Relationship (Type, Print) STEVEN LEBERMAN / SON PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM: 5/18/2004 1 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 /Medical Due to for as a consequence of): **Examiner** Bowel Schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) PO 9 Unknown Pagt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Bleed 1 ☐ Yes 2 D No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate has DIP LIVER Mulh 1 ☐ Yes or Attending Physicien: 25. Was case re erred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 □ M6 Certification: To 1 2 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Diractor: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 005772 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Laurz Steele -9000 FRANKLIN SQUARE DRIVE-BALTIMORE, MARYLAND 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 9 2004

			1 - For State Registrar	State of Maryland /		artment of H			giene Reg. No. 20	04	15975
	Physici /Medi		1. Decedent's Name (First, Middle, Last) DOREEN A •	MOGEY				2. Date of Dea Month MAY 14	Day	Year	3. Time of Death 23:20 M
<b>*</b>	Examir		4a. Facility Name (If not institution, give : NORTH ARUNDEL HO			4b. City, Town, or GLEN B		h	4c. County ANNE		DEL CO.
	Funeral Director		5. Social Security Number 6. Sec 410-78-0268	7. Age (In yrs. last I	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Birthp Cour Ire1	**
	show	ž	Usual Residence of Decedent  10a. State 10b. County  Md. Anne Aru	ndel Co Pa	wm or Lo						0d. Inside City Limits 1 ☐ Yes 2 No
	with the N e or 28e-f	Directo	10e. Street and Number 8252 Bayside Dri			10f. Zip Code 21122			10g. Citizen of	What Cour	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Evandar must be inclined at ance.	by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	İ	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ※ No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Rad Bla	ce Americ ck, White, y: Whi	etc.
21215-0036	within 72 ho ene. than "netur he Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupi kind of work done o DO NOT use retired Homemaker	ation during most of wo.	rking	16b. Kind of B		dustry
and 2	d be filed ental Hygi ked other c event, I	To Be Co	17. Father's Name (First, Middle, Last) Arthur	Holland		Tomemaker	18. Mother's Nar	ne (First, Middle,		ne)	
Maryland	nd 2 shoul Ith and Mari 27 is mari	1	19a. Informant's Name/Relationship <i>(Ty</i> ) John Mogey			ng Address (Street a	and Number or Ru	ıral Route Numbe			Code)
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than 'any injury or other treumatic event, Illia Ma. 2010.		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval mom State		sition (Name of matory or other plac Crematory	l l	Date 8/04	20c. Location		
Balti	permit. P Departm Importer any injur		21. Signature of Funeral Service Licens		-	. Name and Addres	s of Facility Polynia		1 Home	P.A.	
	Medical /Medical Examiner	Examiner	23a. P. m1. Enter the disease, or complishock, or heart failure. List only or mediate Cause (Final isease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	e of):	er the mode of dyin	g, such as cardia	c or respiratory and	rest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed the bas been signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)				te of delive	ry Day Year
	w requires tha been signed I should be det	by	Part II. Other significant conditions cor	tributing to death but not resulting	in the u	nderlying cause give	en in Part I.				e cause of death? ably 4 \text{\text{\text{Unknown}}}
Il Records,		Completed						24a. Was a autops perfor 1 Yes	med?	prior to cor	osy findings available inpletion of cause of
Division of Vital	> .00	ıtlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Factor of Death  1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 ER/0 28a. Date of Injury (Month, Day Year)	Outpatier Time of Injury	28c. Injury Work	er: 4 🗆 Nursing H	ome 5 Residence Residence Residence Page Residence Resid	ence 6 🗆 Oth		')
Divisi	al or Attendii after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S. City or Town		er or Rura	Route Number,
	To the Hospitel or Attending Ph Within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Physical Control (Chack only of e) 2 Medical Exemination	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death and/or in	occurred at the time vestigation, in my op	e, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and ma late and place,	inner as stand due to	ated. the cause(s)
•	To the within To the comp	Me	29b. Signature and title of certifier		۵.	29c. License	number		9d. Date signe		Day, Year)
	5		30. Name and address of person who con Releke Desse	· selven					19/30 1		15 20901
	Sta Regist		31. Date filod (Month, Day, Year)  MAY 1 9 2004	32. Registrar's Signature	G	Sparks	/	1 -101			15 20904

			State of Maryland / Department of Health and Certificate of Death	Mental Hy	200	4 15976
			1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No.	3. Time of Death
	Physici /Medic		Stephen Montanarelli	Month	14. 200 4	
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of De	eath
			Franklin Square Hospital Kose DALE		BALT	imore
	Funeral Director		5. Social Security Number 095-20-5370   6. Sex   7. Agh (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.	8. Date of Bi	21. 1929 N	Sirthplace (State or Foreign Country) IEW York
	9		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			
	Maryla f shov	ō	MD Baltimore Kingsville			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of What	
0	s after death with the Maryland , or itams 23a or 28a-f show cominar must be notified at	Funeral Director	11721 Cedar Lane 21087		USA	
9	er dea	uner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No to Rican, etc.)	o- 14. Race - Ar Black, W	nerican Indian, hite, etc.
STEPHEN 15-0036	urs afte	þ	1 □ Never Married 2 Married 1 ☑ Yes 2 □ No 1 □ Widowed 4 □ Divorced Year or Dates:		Specify:	white
500	72 hours "natural",	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	rkina	16b. Kind of Busines	ss/Industry
-2	ba filed within 72 hotal Hygiene. Id othar than "natu evant, It e Medical	mple	Elementary/Secondary (0-12) College (1-4or 5+)	9	Charl	
920	filed v Hygie othar t		12 5+ State Prosecutor  17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle	State of Maiden Sumame)	Maryland
Maryland	2 should ba filled within and Mental Hygiene. is marked other than aumatic event, It a M.	To Be	Nicholas Montanarelli Margaret	DeL	orenzo	
a Ser	s 1 and 2 should Health and Men tam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			, Zip Code)
	ges 1 and 2 tof Health II itam 27 or other tra	1	Jane W. Montanarelli / wife 11721 Cedar Lane; King  20a. Method of Disposition (Name of	Sville,	MD 21087 20c. Location - City	or Town State
ont C	0 0 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)			
altin	그 두 목 글		^ 4 □Donation 5 □Other (Specify) Dulaney Valley Mem. Grd. 5  21. Signature of Funeral Service Licensee 22. Name and Address of Facility	/19/04	Timonium, 1050 Yo	
- m	Depar Impor any ir	(i. )	michaelf Russ Ruck Towson Funera	1 Home	Towson,	MD 21204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	1		Approximate Interval Between Onset and Death
	Physician / /Medical		resulting in death)	1-tarc	tion	Onsot and oddar
	Examiner		Due to (or as a consequence of):  Caraiac Tampon ac	dA.		
		ner	if any, leading to immediate Due to (or as a consequence of):			
	ecuter and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	alE	Sue to (or as a consequence on).			
9		edlcal	0.		0.730	1
Box	eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	
О.	it the dea by the at tached fo	ysici	in the past 12 months?  1  Yes 2  No 9  Unknown  9  Unknown		Month	Day Year
. P.O.	res that thighed by be detact	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
rds	w requires been sign should be	Completed by Physician/M	End Stage Renal Disease	10	Yes 2 ₩ 3 3 □	Probably 4 Unknown
000	law re as bee 2 sho	plet		24a. Was	an 24b. Were	autopsy findings available completion of cause of
<u> </u>	Attending Physician: The law requires that the death certif or death. actor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Соп		perfo	ormed death:	es 2 No
Vita	aician: Th certificate rector, pag	) Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   1   Monatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing H			
of	g Phys er this eral dii	n: To	27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Sp.	ecify)
io	ttending F death. ctor: After y the funera	atlo	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	Street and Number or i wn, State)	Rural Route Number,
	ours a	al Ce	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the	cause(s) and manner	as stated
	To the Hospital or within 24 hours after To the Funaral Dir.	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	rred at the time,	date and place, and di	ue to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Ň	29b. Signature and title of certifler 29c. License number		29d. Date signed (Moi	nth, Day, Year)
	XI		Sudhalan 1291 hass. Mr Res 00000		May 14,	2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	Man 7	7140-1	mis Mr minn
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature			1169
	Registr	ar	MAY 1 9 2004 Part of Breaks			

DHMH 17 Rev 1/2001

ORIGINAL

			Please		ack Indelible Ink. Ensure		
			for State	State of Maryland	/ Department of Health and	d Mental Hy	giene
			Registrar		Certificate of Death		Reg. No. 4 1 39 /
	Physic: /Medi		1. Decedent's Name (First, Middle, Last	W. MC	Clendon	2. Date of De. Month	ath Day 29ar 10:04 A M
1	Examir	ner	4a Facility Name (If not institution, give	street and number)	4b City, Town, or Location of De		4c. County of Death
			5 Social Security Number 16. Se.	7. Age (In yrs. las	t birthday) If Under 1 Year   If Under 24 F		Dultimore
	Funeral Director			M 2□F 85		in. 8. Date of Birt Month, Da	9. Birthplece (State or Foreign V. CULTOIN A
	land w		10a. State 10b. County	10c. City, 1	Town or Location		10d. Inside City Limits
	72 hours after death with the Maryland "natural", or Itame 23s or 28s-f show offed Exa unar must be notified at	tor	MD Baltimo	ore Rar	ndallstown		1 □ Yes 2 ♠No
	or 28.	Funeral Director	10e. Street and Number	2011 07	10f. Zip Code		10g. Citizen of What Country?
	ath w	rai	8902 MIDDLEBR		21133		USA
	er de Itam	nue		12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin?</li> <li>If Yes, specify Cuban, Mexican, Pu</li> </ol>	(Specify Yes or No- erto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
36	72 hours after natural', or Ita	by F	1 Never Married 2 Married 3 12 Widowed 4 Divorced	1 ☐ Yes 2 ☎No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
21215-0036	72 hours "natural",		15. Decedent's Edu	cation	6a. Decedent's Usual Occupation		16b. Kind of Business/Industry
21		Completed	(Specify only highest grade Elementary/Serpondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of v	vorking	- ( : 6
	filed withi Hygiene. other than	So	9th		Iruck Driver		Irucking Co.
anc	t be findal Hed ot	To Be	17 Father's Name (First, Middle, Last)	endon	7	lame (First, Middle,	Maiden Sumame)
Maryland	should be filed within and Mental Hygiene. ie marked other than eumatic event, the Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	٢	19a, Informant's Name/Relationship (Ty		10h Mailing Address (Street and Numbers	Qual Davia Niverb	
Ma	nd 2 strith ar		Flaing McClendo	0 - daughtee	19b. Mailing Address (Street and Number or	OT ROOM	Idalictouse MA 21122
Je,	es 1 and 3 of Heatth fitem 27 r other tr		20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other place)	Date	20c. Location - City or Town, State
E	Pages nent of I int: If it		1 Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)		zion Cemetery 5-	20-04	Lansdowne ms
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, Ins. M. ADGE.		21. Signature / Funeral Service Lic-	7/	22. Name and Arcress of Facility		200000000000000000000000000000000000000
8	20119		Mary / 11/on	d	Gary P. March F/H	270 Fredt	ilton Pass Balb. Ms 21229
€.			shock of pear failure. List only of	cations that caused the death. I se cause on each line.	Do not enter the mode of dying, such as card	iac or respiratory arr	Interval Between
	Physician /		Immediate Cause (Final disease of condition resulting in death)	METASTAT	IL COLON	CANC	Onset and Death
4	/Medical Examiner		1	Due to (or as a consequen	ce of):		
		er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or as a consequen	ce of :		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
,09	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):		
376	ate be ex hysician he burial	icai					
68 ×	death certificate t attending physic I for use as the E	Med	IF FEMALE:				
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O.	The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
۹.	res that I	P P	Part II. Other significant conditions con	tributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
rds	quires n sigr ald be	d by	MYPERTEN		•		es 2 □ No 3 □ Probably 4 ☑ Unknown
00	aw requir s been si 2 should	piete	DEMENTIA	+		24a. Was a	an 24b. Were autopsy findings available
of Vital Records,	The lav	Completed				autops perform	an 24b. Were autopsy findings available symed? 2 No 1 Yes 2 No
/ita	vician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		26. Place of D	eath (Check only on	
of V	Physician: this certifica al director, j	2	1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/		Home 5 ☐ Reside	ence 6 Other (Specify)
nc U		ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	D. Time of 28c. Injury at Injury Work?	28d. Describe ho	ow injury occurred
Division		licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	M 1 Yes 2 No	206 Lagation (Co	
Di	after after	Certification:	4 Homicide determined	building, etc. (Specify)	, tarm, street, factory, office	City or Town	treet and Number or Rural Route Number, n, State)
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	icien: To the best of my knowled	dge, death occurred at the time, date and place	ce, and due to the ca	ause(s) and manner as stated.
	To the H within 24 To the F complete	fedical		and manner stated.	and/or investigation, in my opinion, death occ	curred at the time, d	ate and place, and due to the cause(s)
	To Too	Σ	29b. Signature and title of certifier		29c. License number		9d. Date signed (Month, Day, Year)
7	1		Vhn M.D		D0059107	- 5	,-14-2004
	1		30. Name and address of person who con			2600 L	-19-2004 -1BERTY HEALMITS AVENUE LORE MD 21215
M	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	MEDICAL GROUP	SALTIM	10RE MD 2/2/5
	Registra		MAY 1 9 2004	32 Registrar's Signature	Angelle )		

			1_ For		yland / Depa	artment of	f Health an	nd Mental Hyg	•	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cel	rtificate o	or Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an	_					Month	Day Y	ear M
10	/Medic Examin		Christine Carol M  4a. Facility Name (If not institution, give s			4b. City, Town	n, or Location of I	May 11	2004 4c. County of	3:00 A
	LAGITIII	C1	3134 Ryerson Cir.			Lans	downe		Balti	more
	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Ye	ar If Under 24	Hrs. 8. Date of Birtl Min. (Month, Day		Birthplace (State or Foreign Country)
	Director		216-34-035/	M 20XF 6	6 Yrs.	inonino Daj	ys Hours			Maryland
	and *		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	cation	<del></del>			10d. Inside City Limits
	Maryl	ō	Maryland Baltimor	e	Lansd	owne				1 ☐ Yes 2 ☑ No
	1 28a	rec	10e. Street and Number			10f. Zip Code	ө		10g. Citizen of Wha	at Country?
	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28a-f ehow than Madical Examiner maal be notified at	Funeral Director	3134 Ryerson Cir.			2122	.7		U. S. A	•
	deat	ner	11. Marital Status	2. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Was Decedent of f Yes, specify C	of Hispanic Origin	? (Specify Yes or No- Puerto Rican, etc.)	14. Race -	American Indian, White, etc.
98	or It		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1	1□Yes 2√∑N		, , , , , , , , , , , , , , , , , , , ,	Specify:	White
Ö	tural'	ed by	3 ₩ Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:		dent's Usual Occ			16b. Kind of Busin	
5	n ns	Completed	(Specify only highest grade	completed)	(Give	kind of work do DO NOT use ret	ne during most of tired)	f working	100. Kind of basis	less maustry
212	yiene giene r tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	В	ar Maid			Liquor	
힏	be filed ital Hygie of other svent,	Be C	17. Father's Name (First, Middle, Last)		_			Name (First, Middle,		
<u>yla</u>	should b and Menti marked umatics	To I	Paul Welton					Leen Foley		
Maryland 21215-0036	C1 10 70 00	1 2	19a. Informant's Name/Relationship (Typ	•				or Rural Route Numbe		
	1 and Health em 27 ther tr		Linda Babb / daugl		20h Place of Disno	sition (Name of		Lansdowr	ne, MD.  20c. Location - Cit	21227
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 □ Cremation 3 □ Re		MD Vetera	natory or other p ns Ceme	olace)	5-14-2004		
芸	iit. Partmei artmei artant injury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	1	of Cro	wnsvill	e 103			ville, MD
B	Depa Impo any ir		Pohund.	24				Home of La		
7.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	e death. Do not enti	or the mode of d	monds re tying, such as ca	rry Rd. I	ansdowne	Approximate
	Physician		Immediate Cause (Final disease or condition	e cause on each line.	in meti	ve He	art F	Failure		Interval Between Onset and Death
5	/Medical		resulting in death)	Due to (or as a c	onsequence of):	10 110	2	0 3		
	Examiner		Sequentially list conditions.	<u>6</u>	nd ST	eje 1	iencl	Distal	il	
7	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):	0				
_	and and II-tran	Examiner	that initiated events c.	Due to (or as a c	onsequence of):					
760,	eath certificate be executed attending physician and for use as the burial-transit	caiE			,					
687	ificate g phy: as the									
Вох	anding use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of p		T-t			23d. Date o	f delivery
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at tim		Ectopic pregnal Other (specify)			Month	Day Year
о. О.	at the	Phys	9 Unknown							
	The law requires that the death certifica ate has been signed by the attending phy page 2 should be detached for use as th		Part II. Other significant conditions con	tributing to death but n	not resulting in the ur	nderlying cause	given in Part I.			te to the cause of death?  ☐ Probably
Ö	requi	eted	to the state of th	220-	-			_		
Records,	has b	Completed	Dissere	) rece	MU)			— 24a. Was a autops perfor	sy prio	e autopsy findings available r to completion of cause of th?
Vital	ifcian: The certificate rector, pag		25. Was case referred to medical					1□ Yes	20-No 10	Yes 2 No
	ysician: The is certificate hadirector, page	To Be	examiner?	ospital:	2 ER/Outpatien	t 3 DOA	Other	Death (Check only or ng Home 5 \ sid	*	Sagaity)
Division of	or Attanding Physafter death. Diractor: After this in by the funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	28c. In			ow injury occurred	Эрөспу)
<u>o</u>	ttandin death. ctor: Alt / the fur	atio	1 Natural 5 ☐ Pending investigation	(Month, Day 1)	Bar, Injury		☐Yes 2☐No			
Σ	l or Attano after death Diractor: i in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)	eet, factory, offic	08	28f. Location (S. City or Town	treet and Number on, State)	or Rural Route Number,
Ω	urs af urs af ural D		You was							
	Hoap 24 ho Funa stely f	Medical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of ner: On the basis of ex and manner stated	amination and/or inv	t occurred at the restigation, in m	e time, date and p y opinion, death o	place, and due to the coccurred at the time, d	ause(s) and manne late and place, and	or as stated. due to the cause(s)
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funaral Diractor: After this certificity completely filled in by the funeral director.	Med	29b. Signature and title of certifier	and manner states	-	29c. Lice	ense number	2	29d. Date signed (A	fonth, Dey, Year)
	- s - ō		M O M	. Attend	MO	1	7503	03	The	Pal
	4		30 Name and address of person who con	mpleted cause of deat	h (Item 23a) (Type,	Print)	- , - )	. 4	7/12	0
_	· ·		Rodolfo Ferno	reet 1	101	105 T	redon	ou ha us	THE 162	21228
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	·				,
4	Registr	वा ः	MAN TO MAN	The Prese	La .					

DHMH 17 Rev 1/2001

ORIGINAL

	***		1- For State of Marylan		artment of H		Mental Hygie	- 2 U i i	4 15979
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Egbert Tatum Murray, Jr.				May 14	Day Year 2004	1150 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) Genesis Elder Care		C	Location of Death	le l		timore
, cre	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 ☐ F 7. Age (In yrs. 79)  Usual Residence of Decedent	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 3,		irthplace (State or Foreign Country) Maryland
	72 hours after death with the Maryland natural', or itema 23a or 28a-f ahow aleal Exemirae mat te moilled at	Director		y, Town or Lo	Arbutu	S			10d. Inside City Limits 1 ☐ Yes 2X No
	a 23a or	eral Dir	1234 Vogt Avenue	5 10.1		1227	Į	Citizen of What C	tates
5-0036	ours after de rat', or item Examinar	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  12. Yes Decedent Ever in U. Armed Forces?  12. Was Decedent Ever in U. Armed Forces?  12. Was Decedent Ever in U. Armed Forces?	TT   "	Vas Decedent of Hi f Yes, specify Cubai I□Yes 21□No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
0-6121	within ane. than	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)	(Give i	lent's Usual Occupa kind of work done d DO NOT use retired, Security	luring most of work )	ing 16b	So our 1 ty	.,
land 2	be file ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last)  Egbert T. Murray, Sr.		Security		e (First, Middle, Maid 11ke	Security den Sumame)	/
, mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  Nina Plitt Daughter	1			al Route Number, Ci		Zip Code)
aitimore,	permit. Pages 1 Department of He Importent: If iten any injury or oth	1	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	emetery, crem view C1		Inc. 5-	17-2004 B		e, MD
ng Pa	Depar Impor any in	1	21. Sign stare of Funeral Service 15	$\sqrt{3}/132$	28 Sulphu	r Spring	rose Funer Rd., Arbu		
	Physician /Medical physician and physician and physician and physician and physician sit physician are physician and physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician a	il Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence cause).	uence of):  1 // Lev  12 ev te	Failure No Sin	such as cardiac	Disea	ů.	Approximate Interval Between Onset and Death
P.U. BOX 68/60	death certific e attending p id for use as	Physiclan/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 ath 5	Ectopic pregnancy Other (specify)	n in Part I	23a Did tohacc	23d. Date of de Month	Day Year to the cause of death?
ecords	law requires that the as been signed by th 2 should be detache	Completed by	Degenerative Joint	1	1. France	-	1 ☐ Yes  24a. Was an autopsy	2 No 3 P	robably 4 Unknown
Vital R	Physicien: The lav this certificate has al director, page 2 a	Be	25. Was case referred to medical examiner?		Othe		performed' 1 Yes 2 1	? death? No 1 \(\sum Yes	s 2 No
VISION OF	fter	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury	28c. Injury Work' M 1 \( \text{Y}	at ?	me 5 Residence 28d. Describe how in	njury occurred	
2	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		28e. Place of Injury - At hombididing, etc. (Specify  29a. Certifier  1 — Certifying Physician: To the best of my known	")			28f. Location (Street City or Town, Str	ate)	
	To the Horwithin 24 h To the Fur	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	on and/or inve	estigation, in my opi	nion, death occurr	ed at the time, date a	and place, and due	e to the cause(s)
	3		30. Name and address of person who completed cause of death (Item	23a) (Type, P	- A	10 ST	- Ente	308	9 Ball m1)2/1
	Sta Registr	ar	31. Date filed (Month, Day, Year) MAY 1 9 2004  32. Registrar's Signat	ure	Sparker		V . 1 . V		
DH	AH 17 Rev 1/20	001			1				

ORIGINAL

			State of Maryland / Department of Health ar Certificate of Death	nd Menta	l Hygie		004	15981
×			1. Decedent's Name (First, Middle, Last)		of Death			3. Time of Death
	Physici /Media		Alexander (nmn) Miller	Mor		Day -	OU	9,50,0 M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of C	Death		4c. Cour	ty of Death	
			Franklin Square Hospital Center Rosedule			Bu	1timo	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours		of Birth	ear)	9. Birth	place (State or Foreign
	Director		215-60-6729 71 Yrs.				Scot	
	and		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location					10d. Inside City Limits
	Marylan f show	ō						1 ☐ Yes 2 📉 No
	the M 28a-f	Director	Maryland Harford Joppatowne  10e. Street and Number 10f. Zip Code		100	Citizen o	f What Cou	nto/?
	th with 23a or	٥	404 Berkshire Court 21085			JSA		,
	or death with the Maryland tems 23a or 28a-f show set must be restilled at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n? (Specify Yes			ace - Americ	can Indian,
9	5 2 F		1 Dever Married 2 Married 1 Des 2 No	Puerto Rican, e	tc.)	В	ack, White,	etc.
, O3	hours after tural', or ite	1 by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:			Spec	ity: Wh	ite
5.0	n 72 hours afte "natural", or i edical Exant	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most or	f working	160	. Kind of	Business/In	dustry
Gnder 21215-		mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)					
× 2	be filed withlital Hygiene. d other than	ပိ	4 Chief Planner  17. Father's Name (First, Middle, Last)  18. Mother's	Nome /First I				ng & Repair
1/e	g e e g	Be	William (nmn) Miller Ina	Name (First, I				
еС, 14 /ексілдес Maryland 21215-0036	s 1 and 2 should be if Health and Mental litem 27 is marked o other traumatic eve	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	(nr			ewart	
S S	and 2 salth ar							
Te,	s 1 au f Hea item othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	200	Location	- City or To	21085 own, State
7 6	Page ent o nt: If ry or		1 Burial 2 X remation 3 Removal from State  '4 Donation 5 Other (Specify)  Cemetery, crematory or other place)  Hilltop Service Corp. 5	/19/04	Tot	zson	Mary.	land
$M_{III}$ Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra <u>QRCB</u> .		21. Signature of Funeral Service Licensee 22. Name and Address of Facility					e, P.A.
ä	Depa Impo any in		Algely Charges 1317 Cokesbury					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	rdiac or respira	tory arrest,	O11#	PICTY	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition					Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):					_ LODUY
	Examiner		Sequentially list conditions, b.					
	D iii	Examiner	if any, learning to immediate cause. Enter Underlying Cause, Disease or injury					
	and I-tran	хаш	cause (Disease or Injury that infitated events resulting in death) Last  Due to (or as a consequence of):				_	
8760,	be ei ician buria	E E	- Sub-to-(of as a consequence or).				1	
687	ate hys	dlcai	d					
Box (	leath certific attending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	150		224 D	ate of delive	
m m	death atter	ciar	n the past 12 months?  1 ☐ Ves 2 ☐ No  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				lonth	Day Year
40	the by th ache	nysi	9 Unknown					
, <del>C</del>	w requires that the been signed by the should be detache	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I,	23e.	Did tobac	co use cor	tribute to th	ne cause of death?
Ę	quire an sig uld b	pa P	coronary a tory dispuse		1 ☐ Yes	2 🗆 No	3 🗆 Prob	ably 4 Unknown
S		piet		24a.	Was an	24b	Were auto	psy findings available
æ	The law cate has b page 2 st	E			autopsy performed Yes 2 🔀		prior to cor death? 1 ☐ Yes	inpletion of cause of
<u> </u>	nding Physician: Th th. : After this certificate s funeral director, pag	Be C	25. Was case referred to medical 26. Place of	Death (Check		NO	10105	2 140
>	Physician: this certificatal director.	To	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 Froutpatient 3 DOA Other: 4 Nursin	ng Home 5	Residence	6 □Ot	her (Specify	()
D C	ng P		27. Manner of Death  1 □ Natural 5 □ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Unique Work?	28d. Des	cribe how is	пјигу осси	rred	
sio	Attending r death.	cati	2 Accident investigation M 1 Yes 2 No					
Division of Vital Records,	or At after of Direct in by	Certification;	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide	28f. Loca City	tion (Street or Town, St	and Num ate)	ber or Rura	l Route Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	lace and due to		(-) 1		
	24 hos Fun etely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	occurred at the	time, date	and place	anner as st , and due to	ated. the cause(s)
	To the Hospital or Attencyinin 24 hours after death To the Funeral Director:	Me	29b. Signature and title of certifier 29c. License number		29d.	Date sign	ed (Month, l	Day, Year)
	. 1		D00553	45	5	114	104	
	り		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1 1	- 1	4.
_			DERWING PHILLY MIS 9000 Franklin Square Di	Tive B	Itin	ire.	4d. 2	1237
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature			, -		
	Registr	uı	MAY 1 9 2004 Separate Aparts					

1			1 - For Unpend Item #23	State of Ma,27,28a I	aryland / Dep. per me 6832 ( <i>Ce</i>	artment of H 12/04 tas rtificate of I	lealth and Death		ene 2004	15981
			1. Decedent's Name (First, Middle, Last,					2. Date of Death		3. Time of Death
	Physici /Medi		Melvin Michael N	ionroe				May 12,	2004 Year	0700 A M
7	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath	4c. County of Death	
3			116 North Paca S	Street #5	03	Baltim			N/A	
0	Funeral		5. Social Security Number 6. Sec	7. Ag M 2□ F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	n. (Month, Day, 1	rear) Cou	place (State or Foreign ntry)
7	Director		215-70-4649	201	46 Yrs.			Jan. 25,	1958 Mai	yland
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation		-		10d, Inside City Limits
	Marylan I show	Į.	MD N/A			Balt	imoro			1X Yes 2 □ No
	the 28a	Director	10e. Street and Number			10f. Zip Code	LIHOLE	100	g. Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show Frnust by notified at		116 North Paca Str	eet Apt.	503	212	201	Ţ	Jnited Stat	.00
	deatl	Funeral		12. Was Decedent Armed Forces?				(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri	can Indian,
9	after or Ita		1 X Never Married 2 ☐ Married		№ 3 <b>–</b> 1976	1 Tes, specify Cuba 1 □ Yes 212 No	Specify:	ano rican, etc.)	Black, White,	
93	be filed within 72 hours after death with the Maryla nat Hyglene. Id ether than "natural", or Itams 23a or 28a-1 show event, I're Medicul Everinet mast be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	5-7-1976	1 L 163 2 2 1 NO	Specify.		Specify: W	iite 
5-(	72 h natu	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	(Give	dent's Usual Occupa kind of work done of	durina most of w	orking 16	6b. Kind of Business/In	dustry
12	within sne.	mp	Elementary/Secondary (0-12)	College (1-4or 5	5+) //fe.	DO NOT use retired	"			
2	illed y Hygie ther t	ပိ	12   17. Father's Name (First, Middle, Last)			Roofer	18 Mother's N.	ame (First, Middle, Ma	Construct	ion
and	od of	Be						•	iden damame)	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Its Ms	T <sub>o</sub>	Melvin Junior Monr  19a. Informant's Name/Relationship (Ty		19h Mailir	ng Address (Street a		Snyder	City or Town, State, Zip	Codel
Ma	nd 2 s lith ar 127 ls 1 trau									
ē,	Hea Hea tem		Melvin J. Monroe,  20a. Method of Disposition		20b. Place of Dispo	sition (Name of			MD 21223 c. Location - City or To	
or or	Pages nent of I nt: If its		1 ☐ Burial 2 🛣 Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bayview C	natory or other plac	1	_17_0/	D = 1 + 4	MD
Baltimore,		1	21. signature of Funeral Service License	1 L					<u>Baltimore,</u> ral Home,	
Ba	permit. Departr Imports any inju		mhoring NK	Mord				ng Rd., Ar		21227
			23a. Part 1. Enter the disease, or compli	cations that caused	the death. Do not ent					Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final		<sub>10.</sub> (Methadone) I	ntovication				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	l,	a consequence of);	IIUXICALIUII				
В	Examiner									
_	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	ecute ind trans	Examiner	that initiated events resulting in death) Last							
8760,	zate be executed obysician and the burial-transi		rosulting in doutiny East	Due to (or as	a consequence of):					
87		dical		l						
9 x	The law requires that the death certific tte has been signed by the attending r page 2 should be detached for use as	/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of delive	200
Box	atter atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □Live birth 4 □ Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
0	t the d by the lached	hysi	9 Unknown	9□ Unknown						
σ,	s that ned b	by Physician/M	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
rds	w requires been sign should be	ed						1 ☐ Yes	2 ☐ No 3 ☐ Prob	ably 4 Unknown
Records,	awre as be 2 sho	Completed						24a. Was an	24b. Were auto	psy findings available
Ä	: The la	mo;						autopsy performe 120Yes 2	d? death?	npletion of cause of
Vital	Physician: this certific ral director,	Be (	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one)		
of V	Physic this co	2	1X Yes 2 □ No	ospital: 1  Inpatie			4   Nursing	Home 5 ☐ Residence	ce 6 Other (Specify	) At scene
ם	ding P	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju	Year) 28b. Time of	28c. Injury Work		28d. Describe how	injury occurred	
sio	Attending r death, sctor: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ▼ Could not be	5-12-04	6:46		res 2 <b>X</b> No	Unknown		
Division	or Al after of Direction by	Certification;	4 Homicide	building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		City or Town,	State) 116 N. Pa	Route Number, #50
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifying Phys	Found: Resident To the best	of my knowledge, death	occurred at the tim	e date and plac		ty, Maryland	ated
	s Hos	Medical	(Check only and Medical Examinations)	ner: On the basis of and manner sta	examination and/or inv	estigation, in my op	inion, death occ	curred at the time, date	and place, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	1 10		29c. License	number	29d	. Date signed (Month,	Day, Year)
			I Leden L	1. 10	4	o.c.	M.E.		May 13, 20	04
			30. Name and address of person who co	mpleted cause of					TRAÑO SERVICIO	
-		Ш	1 1	1, Ky			eet, Ba	ltimore,_M	aryland 21	201
1	Sta		31. Date filed (Month, Day, Year)	37 Fegistra	ar's Signature	all?				
14	Registr	ar	MAY 1 9 2004	A RUSE	I For Paris					

			State of Maryland / Department of He	alth and Me	oopies Are	Legible.
			1- State of Maryland / Department of He state Registra MEND TIFM #17818 PER FH C831 5/19/0 Certificate of D			2001 15000
			1. Decedent's Name (First, Middle, Last)		Reg. No. 2. Date of Death	3. Time of Death
>	Physici /Medio Examir	cal	James Nutt  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or L	ocation of Death	May 15,	2004 10:00 M
	Examili	ier	Future Care Charles Village Balt	imore	,	MA
	Funeral Director		5. Social Security Number  3. Social Security Number  3. Social Security Number  4. Age (In yrs. last birthbay)  4. Months  5. Social Security Number  7. Age (In yrs. last birthbay)  4. Months  6. Sex  7. Age (In yrs. last birthbay)  7. Age (In yrs. last birthbay)  8. Social Security Number  9. Age (In yrs. last birthbay)  9. Months  1. Mo	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Year) Dec. 6, 19	9. Birthplace (State or Foreign Country),
	and w.		Usual Residence of Decedent  10a. State 10b. County ( 10c. City, Town or Location			10d. Inside City Limits
	he Maryl 28e-f sho	Director	Maryland NA Baltimore 10e. Street and Number 10f. Zip Code		10.00	1 Yes 2 □ No
	3a or		2327 N. Charles St. 212	218	Tog. Citi	izen of What Country?
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisp Armed Forces? 15. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Speci	ify Yes or No-	14. Race - American Indian, Black, White, etc.
215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If item 27 is marked other then "neturel", or Items 23a or 28e-f show or other fraumatic event, the Madical Examinar rust be rectified at	by	1 Never Married 2 Married 1 Yes 2 No	Specify:	, 0.02,	Specify: Black
15-(	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during the Do NOT use retired)	ion Iring most of working	16b. Ki	ind of Business/Industry
212	d withi	omp	Elementary/Secondary (0-12) College (1-4or 5+)	r		hipyard
	be filed tal Hygli d other event, I	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (I	First, Middle, Maiden	Surname)
yla	should be ind Mental marked o	To	WILLIAM NUIT — unk	EVA NU		unk
Maryland	d 2 shotth and the and traum		19a. Informant's Name/Relationship (Type, Print Trans 19b. Mailing Address (Street and	0	0+5	r Town, State, Zip Code)
re,	s 1 and f Health item 27 other tr		20a. Method of Disposition (Name of cometon), committee of the committee o	Drrain		ocation - City or Town, State
altimore	Pages nent of I int: If its iry or o		1 Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	5/21/2	2004 LA	nsdawne. Md.
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address	of Facility Russ F	uneral t	tome Md. 21216
			23a. Part Enter the discress, or complication that cause the death. Do not enter the mode of dying, show, or heart failure. List only one cause on each line.	such as cardiac or r	respiratory arrest,	Approximate Interval Between
1	Physician		Immedia e Cause (Final disease or condition a. Alkero Sclevolic Co	ardioVi	iscular 1	Difference Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	not	olla	
	•	e.	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	e Mel	i	
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c	, tense	an	
0,	te be executed ysician and ie burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760	> 0	dlcal	d			West of the second
Вох 68	death certifica attending ph d for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
		Physiclan/Med	in the past 12 months?  1  Yes 2 No  No  No  No  No  No  No  No  No  No			Month Day Year
P.0	that the de led by the a detached f		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23a. Did tobacco u	ise contribute to the cause of death?
Records,	sign d be	ed by			1 ☐ Yes 2 [	/
eco	e law requ has been je 2 shoult	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E R	: The cate had	Соп			performed?	death? 1 Yes 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	examiner?	26. Place of Death (0		
of	Phys or this oral di	To to	27. Manner of Ceath 28a. Date of Injury 28b. Time of 28c. Injury a	Nursing Home	<ul> <li>5 ☐ Residence 6</li> <li>d. Describe how injury</li> </ul>	
ion	Attending I death. ctor: After y the funer	atlor	1 Natural 5 Pending (Month, Day Year) Injury Work?	es 2 🗆 No		
Division	Il or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Surcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f	f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated	, date and place, and nion, death occurred	d due to the cause(s) at the time, date and	and manner as stated. place, and due to the cause(s)
	To the within 2 To the Comple	Mec	one) and manner stated.  29b. Signature and title of certifier 29c. License n	number	29d. Date	e signed (Month, Day, Year)
	⊢≱⊢ŏ			641	Ma	4 17 200 4
	18				111.0	1 1/2/1/
			30, Name and address of person who completed cause of death (Item 23a) (Type, Point)  Rauch Sa Dapalvi 3400 Eva Man A  21 Data filed (Month Day York)	venve	DalAM	ne 1944/442/45
	Sta Registi	9 47	31. Date filed (Month, Day, Year)  MAY 1 9 2004  Jones Signature			/

			i icase i	State of Maryla				•	•	
			1 - State	State of Maryt		rtificate of			- 21111	+ 15983
			Registrar  1. Decedent's Name (First, Middle, Last)			tinoute or	Douth	Reg. 2, Date of Death	No.	3. Time of Death
	Physici		Marchas		oute			Month	Day Year	4 20:08PM
-	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	1/01/		or Location of Death		4c. County of De	1
			THE JOHNS HOP	KINS HOSY	pital		nore (	ity		
	Funeral		5. Social Security Number 6. Sex		rrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 11 07	ar) 9. Bi	rthplace (State or Foreign country)
	Director		250-41-8056 Usual Residence of Decedent	<sup>KM 2□ F</sup> 26	115.			11 07	77	SC
	/land		10a. State 10b. County	10c.	City, Town or Lo	ecation				10d. Inside City Limits
	Man 9-1 sh	tor	MD NA	В	altimo	re				1X Yes 2 □ No
	th the	lrec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	23e	Funeral Director	903 Druid Park I	Lake Drive	Apt 2		21217		U.S.	Α
	er de t	nue	11. Wanta Glates	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	within 72 hours after death with the Maryland one. then "naturel", or Items 23e or 28e-1 show the Medical Exartment to 1 citified at	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2√2 No If Yes, Give Year or Dates:		1□Yes 🚜No	Specify:		Specify:	Black
21215-0036	2 hou	led	15. Decedent's Educ	eation	16a. Dece	dent's Usual Occup	pation	16b	. Kind of Busines:	
215	hin 73	ple	(Specify only highest grade	Completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of working)	ng		,
2	filed wit Hygiene other the	Completed	12th grade	na		Student	,		Stude	nt
nd	be file tal Hy doth eveni	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maio	len Sumame)	
<u>\</u>	should I	5	Bernard Cunningh				Emma Yv	onne Out	en	
Maryland	0 0 0 0		19a. Informant's Name/Relationship (Type							Zip Code) 21217
	1 and 2 Health tem 27		Emma Yvonne Joh 20a. Method of Disposition	nson-Moth	<ul> <li>b. Place of Dispo</li> </ul>	sition (Name of			Location - City o	
nou	Pages nent of int: If it		XBurial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory`or other plac	· 1			
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Fineral Service License		Charles and the Beauty	Name and Addre	ial 5/22	/U4 K1	.cmiiona	Co., SC
ã	permit. Departr Importe any inji	. 10	Maly MI	arch	4.	300 Waba	ash Ave,	Baltimo	re Md	21215
	10		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the d	eath. Do not ent	er the mode of dyir	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Klebsie,	la pre	mon.a	bactere	~.c		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons		31 1 101	Deleto	11100		1.0010
	Lxammer	L	Sequentially list conditions, b			itstina	1 bleed	d		1 day
	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence or):					
1	be executed ician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a cons	sequence of):					
760	icate be executed physician and s the burial-transit	cal								
89	tificat ng phy as th									
Вох	th cer tendir r use	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	/		23d. Date of de	*
O.	e dea the at	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
<u>G</u>	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	Part II. Other significant conditions con	tributing to death but not	resulting in the u	ndorhijaa oayee aw	on in Part I	23a Did tohace	a usa contributo t	o the cause of death?
ds,	signe d be c	d by		rodefic, ency	-	Kome	on in raiti.	1 Tes		robably 4 Dunknown
Ö	requir been s should	etec		0	7.77.10	WONTE		24a. Was an		utopsy findings available
Records,	2 2 8	Completed by	Incombocyta pen					autopsy performed	prior to death?	completion of cause of
Vital	iclen: Th certificate rector, pag		25. Was case referred to medical	M-Cobacter:	im avic	in conf	26. Place of Death	(Chack anly and)	Vo 1 ☐ Yes	2 No
>	Physiclen: this certificated director.	To Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Hor		6 □Other (Spe	ecify)
J Of	ding Phys I. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of		y at 2	8d. Describe how in		,
Sio	Attending It death. ector: Afte	atic	2 Accident investigation		, , , , ,		Yes 2 □ No			
Division	or Att fter d jrect n by t	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecity)	eet, factory, office	2	28f. Location (Street City or Town, Sta		ural Route Number,
	pitel ours a erel E		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge death	a conversed at the time	no, data and place of	and due to the serves	(a) and manage	
	24 hcs Fun etely	Medical	(Check only 2 Medical Examin	er: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	pinion, death occurre	ed at the time, date a	ind place, and du	s stated. to the cause(s)
	To the Hospital or Attending Physiclen: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	1717		29c. Licens	e number	29d. [	Date signed (Mon	h, Day, Year)
	V- > F 0		Maritas S.	leus no	0	RF <	-000	Me	1 17	2004
	n.		30. Name and address of person who con		Item 23a) (Type,	Print)	000	11101	1 1	
	'7		Courtry Bellaus	Coo North a	valle Sta	cet, Mark	Na B-186	Baltimore	Mergene	2004
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 9 2004	32. Registrar's Si	gnature	na. J.	0		0	
	riegisti	41		/ /	- Just	o color				

1-   December Name Prize Moss. Latt)   JOHN E. PORTER, JR.   2-   December Notice   Day   Year   May 14, 2004   Year   May 14, 2004   Year   May 14, 2004   Year   May 14, 2004   Year   May 14, 2004   Year   May 14, 2004   Year   May 14, 2004   Year   Accompt of General Participant   4s. Clay, Town, or Location of Death   May 14, 2004   May 14, 2004   Year   Year   May 14, 2004   Year   Year   May 14, 2004   Year   Year   May 14, 2004   Year   Year   May 14, 2004   Year   Year   May 14, 2004   Year			For State Registrar		epartment of Health and Certificate of Death	Mental Hygie	_	1598
Top   Top			JOHN E.	PORTER, JR.		Month MAY 14	Day Year 2004	3. Time of Death  10:50 P
100. Street and Number 720 Washington Ave.  101. Zp Code 21060 U.S.A.  102. City, Town or Location Glen Burnie  102. Code 21060 U.S.A.  103. Was Decedent Hispanic Origin? (Specity Yas or Number 720 Washington Ave.  103. Was Decedent Hispanic Origin? (Specity Yas or Number 720 Washington Ave.)  104. Race - American Indian. These Street Indians or Origin? (Specity Yas or Number 720 Washington Ave.)  105. Levelore Facultation or These Street Indians or Origin? (Specity Yas or Number 720 Washington Ave.)  106. Kind of Business/Industry Militer Street Indians or Origin? (Specity Yas or Number 720 White Code)  107. Fabrier Name (First, Middle, Last)  108. Was Decedent Value Code or Value (Value Valu	Funeral	er	720 WASHINGTON A <sup>1</sup> 5. Social Security Number 6. Se 213-32-3258	VE.	GLEN BURNIE  If Under 1 Year   If Under 24 H  Months   Days   Hours   M	rs. 8. Date of Birth in. (Month, Day, )	ANNE ARU	NDEL CO. thplace (State or Foreign ountry)
Tr. Father's Name (First, Middle, Last)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Mailden Sumame)  Regina  19. Malling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  Marie M. Orem  (Daughter)  19. Malling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  Marie M. Orem  (Daughter)  19. Malling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  Marie M. Orem  (Daughter)  20. Meghod of Disposition  In Burial 2 Cremation 3 Removal from State  Clen Haven Mem. Pk. 05/19/2004 Glen Burnie, Md  21. Signature of Funger Sarvice Licensee  22. Name-ph-Address of Escillo  12. Signature of Funger Sarvice Licensee  22. Name-ph-Address of Escillo  12. Signature of Funger Sarvice Licensee  22. Name-ph-Address of Escillo  12. Signature of Funger Sarvice Licensee  22. Name-ph-Address of Escillo  22. Name-ph-Address of Escillo  22. Name-ph-Address of Escillo  23. Pp.M. Enter the disease, or complications that cashed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  12. Signature of Funger Sarvice Licensee  22. Name-ph-Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  23. Pp.M. Enter the disease, or complications that cashed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  10. Approximately completed the death of the de	th the Maryland or 28a-f ahow e rollified at	irector	Md. 10b. County Md. Anne Aru  10e. Street and Number	indel Co. Glen B	urnie	100		10d. Inside City Limits 1 □ Yes 2 No ountry?
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Regina  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Mother's Name (First, Middle, Last)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Mother's Name (First, Middle, Last)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Mother's Name (First, Middle, Last)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Mother's Name (First, Middle, Last)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Mother's Name (First, Middle, Last)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  18. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19. Maling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19. Maling Address (Sireet and Number or Rural Route Number, City or	irs after death wi	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	te, etc.
23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals lesses or condition resulting in death)  Physician Medical  Examiner  Approximation as cardiac or respiratory arrest, Intervals Monstal and Constant And Const	ed within 72 hou ygiene. ner than "natura	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) ( College (1-4or 5+)	Give kind of work done during most of v life. DO NOT use retired) Maintenance Superv	isor	MD Aviati Administr	on
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Per pure pure pure pure pure pure pure pu	should be fill and Mental H marked ott	To Be	John E. Por	уре, <i>Print)</i> 19b. I	Regina  Mailing Address (Street and Number or	Rural Route Number, (	Bidding	
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Per pure pure pure pure pure pure pure pu	Pages 1 and 2 ment of Heatth a ant: If item 27 is ury or other tra		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ F	20b. Place of Commetery	Disposition (Name of , crematory or other place)  aven Mem. Pk. 05/	Date 20	oc. Location - City or	ie, Md.
Physician (Medical Examiner    Part   Composition   Compos	permit. Departimpo		Thurs &	Danma	3204 Mountain	Road, Pas	adena. Md	A . 21122  Approximate Interval Between Onset and Death
The secution of death) Last  Due to (or as a consequence of):    Consider the second of the second o	/Medical	4	isease or condition resulting in death)	Due to (or as a consequence of	n: RANSPLANTA	T10~		2 MONTH
9 Unknown  9 Unknown	ite be executed sysician and re burial-transit	cai Examin	resulting in death) Last	c. HEPATITS  Due to (or as a consequence of	C			10 YEARS
	the death certifica by the attending phached for use as the	nysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖾 No	1 Live birth 2 Fetal death 4 Pregnant at time of death				
	equires that en signed b	ed by PI					. 1	o the cause of death? robably 4 Unknown
28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes 2   No  28. Location (Street and Number or Rural Route Nu City or Town, State)						autopsy performe	prior to death?	completion of cause of
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Nu City or Town, State)	anding Physicia ath. r: After this certi	ToB	examiner? 1 Yes 2 Ho  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yeer)	patient 3 DOA Other: 4 Nursing me of 28c, Injury at Work?	Home 5 Residen	ce 6 □Other (Spe	ecify)
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Hospital or Atte		4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc. (Specify)  ysician: To the best of my knowledge,	death occurred at the time, date and pla	City or Town,	State)	s stated.
D53590 MAY 17, 200	To the Ho within 24 To the Fu completel	Medic	one)	and manner stated.	29c. License number	90 1	d. Date signed (Mon	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 624 NORTH BRUADWAY SYDNEY DY, MD ROOM 609 BALT (MORE MD 21090  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature,	10		1	*	Type, Print) 624 NORT BALTIN	H BRUAG	0 210°	90

			1 - For State Registrar	State of	Marylan	d / Depa	artment rtificate	t of H	ealth a	and M	lental Hy	giene ,	2001	+ 15985	5
п	Physici	20	1. Decedent's Name (First, Min	ddle, Last)							2. Date of De	aath Day	Year	3. Time of Death	
>	Physici /Medio Examir	al	Karl Joseph 4a. Facility Name (If not institu				4b. City,	Town, or	Location of		May	15	2004 ounty of Dea	2:11P M	1
			Frederick	Memorial	Hospi	tal	F	red	eric	k		Fr	eder	ick	
	Funeral Director		5. Social Security Number 209-24-0930	<b>X</b> M 2□ F	72 Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir Nov • 1	<sup>th</sup> Увад 9.	31 Per	nthplace (State or Foreign Insylvania	7
	and w		Usual Residence of Decedent  10a. State 10b. Cou		10c. City	, Town or Lo	cation							10d. Inside City Limits	_
	Manyl 1 sho	ō	Maryland Fre	ederick		rederi								Yes 2 □ No	
	28a-	rect	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What C		_
	3a or	Ϊ́	110 Burgess	Hill Way				<b>17</b> 02				U.S.		,	
	deatl	ner	11. Marital Status	12. Was Deced	ent Ever in U.S	S. 13.	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14	Race - Am	encan Indian,	_
9	after or ite	/Fu	1 ☐ Never Married 2 🔀 M	Married 1XXYes 2	□No Wor	·ld	1 □ Yes 2		Specify:	, Pueno	rican, etc.)		Black, Whi	te, etc. Nhite	
8	ural',	d b	3 Widowed 4 Divord	ed Year or Date	∍s: War	2						3,	Decny. V	MITTE	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show its Modical Exertinas for rutified at	Completed by Funeral Director	15. Deced (Specify only hig	dent's Education thest grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done di	tion uring most	of worki	ing	16b. Kind	of Business	/Industry	
12	within ene. than	duc	Elementary/Secondary (0-12	2) College (1-4	or 5+)		ntory					A110	v Meta	al Wire Co.	
	Hyginather aut, 1	e Č	17. Father's Name (First, Midd	fle, Last)	!				18. Mothe	r's Name	(First, Middle				
a	uid be fental rked ric av	To Be	Charles	s Pfirsching					P	Anna	Bayer				
, Maryland	and 2 shou alth and N 127 is ma ar traums		19a. Informant's Name/Relation Karla Malmstro								Chest				
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Executing transities for rullified at angle.		20a. Mathod of Disposition 1 ⚠ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 Removal from St.	20b. Pl	lace of Dispo emetery, crer nlenen	sition (Nam natory or ot LE. Ce	e of her place <b>meter</b>	y N		O, 2004		tion - City or nton,	Town, State PA	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Servi	ce Licensee	M00255	5	к <del>еене</del> 106 Е	y^dana ast	d Bas Churc	forc h St	PA Fu	neral deric	Home k, MD	21701	
760,	eath certificate be executed attending physician and attending physician and for use as the burial-transit	cal Examiner	23a. Part1. Enter the disease shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ener U Jonying Cause (Disease or injury that initiated events resulting in death) Last	a	as a conseque as a conseque as a conseque	ience of):  Augustiance of):	er the mode	e of dying	, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Between Onset and Death	フラー
P.O. Box 68	t the d by the tached	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 □ Fetal It at time of de	death 3	Ectopic pre					230	L Date of de Month	livery Day Year	
	w requires tha been signed should be del		Part II. Other significant cond	litions contributing to deal	th but not resu	Ilting in the ur	nderlying ca	use giver	n in Part I.		23e. Did to	· V	7	the cause of death?	
Il Records,		Completed									24a. Was autor perfo 1 \(\subseteq\) Yes			utopsy findings available completion of cause of	
Vital	ılcian: Th certificate rector, paç	Be	25. Was case referred to medi examiner?							of Death	(Check only o	пе)			
of	Phyelcian: this certific ral director,	J.	1 Yes 2 No			ER/Outpatien		And production	4 🗀 Nur		ne 5 Resid			cify)	
	ng ffter ine	lon	27. Magner of Death 1 Natural 5 Pen		Day Year)	28b. Time of Injury		Vork?	?	1	28d. Describe l	now injury o	ccurred		
isi	or Attanding after death. Diractor; Aftel in by the fune	icat	3 ☐ Suicide 6 ☐ Cou	estigation	Injury - At hor	mo farm str	M	_	es 2□N		96 Location /	Stroot and A	lumbos os O	ural Route Number,	
Division	i or Attandi after death. Diractor; A in by the fu	Certification:	4 Homicide dete	building	etc. (Specify)	)	et, ractory,	OILICE		2	City or Tov	vn, State)	uniber of At	urai Houte Number,	
	To tha Hospital or Attani within 24 hours after deat To tha Funeral Diractor; completely filled in by the	edical C	29a. Certifier (Check only one) Certifier Medic	ying Physician: To the be cal Examiner: On the basi and manner	s of examinati	vledge, death ion and/or inv	occurred a restigation,	t the time in my opi	o, date and nion, deatl	l place, a	and due to the	cause(s) and date and pla	d manner as	s stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of cert	ifier npn				License				29d. Date s	gned (Monti	h, Day, Year)	_
			* X MI	I Carfon	n			ワー	139	7/		57,	15/6	04	
-	13		30. Name an address of pers Robert L. Ka	on who completed cause of aufman, M.D.	of death (Item	<sup>23a)</sup> (Type, West	Print) Ninth	Str	eet,	- Fred	lerick,	MD 21	1701		
К.	Sta Registr	De-	31. Date filed (Month, Day, Ye MAY 1 9 2004		istrar's Sanati	Spo.	the								

			1 ← For State Registrar	State	of Maryl	and / Depa	artment of F rtificate of	lealth and M Death		ene 200	4 15986
ı	Physici		1. Decedent's Name (First, Betty	Middle, Last)  J. Pitcock					2. Date of Death Month May	18, 2004	3. Time of Death 5:50 A M
	, /Medic Examin		4a. Facility Name (If not ins		umber)		4b. City, Town, o	r Location of Death	Mag	4c. County of Dea	
				e Gardens a			Parkvi			Balti	
	Funeral Director		5. Social Security Number 195-14-0876  Usual Residence of Deceder	6. Sex 1 □ M 2 □ X F	7. Age (In ) 80	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) JUNE 10,	1923 Pen	rthplace (State or Foreign Jountry) NSYLVANÍA
	yland sow		10a. State 10b. C		10c.	City, Town or Lo	cation			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	e Mar Sa-f sh	ctor		altimore			Parkvi	lle			1 ☐ Yes 2 ☑ No
	with th	Director	10e. Street and Number 8820 Walther	r Rand An	+ #2101		10f. Zip Code 2 1 2	21	100	J. Citizen of What C	ountry?
	ns 23	Funerai	11. Marital Status	12. Was De	cedent Ever i		1.		ecify Yes or No-	U.S.A.	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at anone.	by	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Div	Armed 1 ☐ Yes	Forces? 2 XNo Sive	į	fYes, specify Cuba 1 □ Yes 2 💢 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
20	72 hc natur	eted	15. De (Specify only	cedent's Education highest grade completed	d)	(Give	lent's Usual Occup	durina most of worki	na	b. Kind of Business	
121	within ene. than '	Completed	Elementary/Secondary (0	0-12) College 5+	(1-4or 5+)		OO NOT use retired	n ation Tea		Baltimore Public Sc	
	e filed Il Hygi other	Be Co	17. Father's Name (First, M			Jacob Cr	tess care	18. Mother's Name			noozs
ylar	ould b Menta arked atic e	To E		nauer				May	Elmire		
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Rel		wah tak			and Number or Rura			
	s 1 an f Heal itam 2 othar		20a. Method of Disposition		20	b. Place of Dispo		e Dr., Ba		MD 2123 c. Location - City or	
<u>E</u>	Page: nent o ant: If ury or		1 ☐ Burial 2 ☒ Crem: `4 ☐ Donation 5 ☐ Otl	ation 3 Removal from	n State B		Crematory		/2004 Ba	ultimore,	Maryland
Baltimore,	permit. Departr Importe any inji		21. Signature of Juneral Se	ervice icentee		22	Name and Address 705 Bela	ir Rd., B	imunek Fi altimore.	ineral Hoi MD 212.	
	Physician	8 1	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ase, or complications that a. List only one cause on a.	caused the deach line.		er the mode of dyin	g, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		, southing it south,	Due to	o (or as a cons	sequence of):	dom	sution of			months
	D =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Duut	(or as a cons	sequence of):	OC1.	CI Med			
2	xecuted and Il-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a cons	sequence of):	_				
68760,	ificate be executed g physician and as the burial-transit	edical E		d.	,						
Box 6			IF FEMALE: 23b. Was decedent pregna in the past 12 months	1 1 ive	utcome of pre		Ectopic pregnancy			23d. Date of de	livery Day Year
P.O.	the dea	Physician/M	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	4□Pre	gnant at time of nown	of death 5	Other (specify)			Month	Day Teal
	The law requires that the death certivite has been signed by the attending age 2 should be detached for use a	þ	Part II. Other significant co	onditions contributing to	death but not	resulting in the ur	derlying cause give	en in Part I.	23e. Did tobad	7	o the cause of death?
Division of Vital Records,		Completed							24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
<u> </u>	sician certifii rector	o Be	25. Was case referred to m examiner?	Hospital-	7		Othe	26. Place of Death			
on of	ding Phy a. After this funeral d	-		28a. Dat	of Injury onth, Day Year	28b. Time of Injury	28c. Injury Work	4 Nursing Hon	ne 5 ∐ Residenc 8d. Describe how	e 6 Other (Specinjury occurred	cify)
Divisi	al or Attance after death Diractor: d in by the	Certification:	3 ☐ Suicide 6 ☐ C	Could not be	ce of Injury - A ding, etc. (Spe	t home, farm, streecify)			28f. Location (Stree City or Town, S	at and Number or Ru State)	ural Route Number,
	To the Hospitel or At within 24 hours after of To the Funaral Direct completely filled in by	Medical C	29a. Certifier 1 Ce (Check only one) 2 Me	ertifying Physician: To the dical Examiner: On the and ma	ne best of my l basis of exam nner stated.	knowledge, death ination and/or inv	occurred at the time estigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	ğ	29b. Signature and title of co	certifier			29c. License		29d.	Date signed (Monta	Ha In
	6		(1/	11//		An - 00:15 T	Dr 3			1 1/10	500 Y
	Ψ		30. Name and seriess of pr	Londomin	39	11 mm 00		Pak	will m	10 212.	34
	Sta Registr		31. Date filed (Month, Day,		Registrar's Sig	gnature	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sean Adam Peters State of Maryland / Department of Health and Mental Hygiene For State Registrar 04-03265 1-Certificate of Death RJ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 14, 3. Time of Death Year Physician 2004 May 0719 A. M Adam Peters /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 920 Bayard Road Harwood ler 1 Year | If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year) July 24,1986 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 10XM 2□ F Yrs Director 215-31-9251 17 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Anne Arundel Harwood 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4742 Flanders Lane, No. N or Items 23a 20776 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after ☐Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Yes. Give 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) then College (1-4or 5+) s 1 and 2 should be filed within theelth and Mental Hygiene. Item 27 Is marked other then Student Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Alonzo Peters 2 Cathleen Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Alonzo Peters (Father) 4742 Flanders Lane No. N, Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of P
Important: If ite
eny injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5/17/2004 Baltimore, MD 21. Signature of Funeral Service Properties 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a HULTIPLE INDVRIE resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy The law requires that the death jo Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificete 2□ No 1X Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) At SCENE 1 XYes 2 No 2 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation or Attending 1 Natural DRIVER OF CAR THAT COLLIDED death. 1 ☐ Yes 2 No 7:11 A 5/14/04 2 Accident WITH FIXED OBJECT within 24 hours after deatl To the Funerel Director: in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ROAD 920 BAYARO RO, HARWOOD, MD Hospital pellil 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29b. Signature and title of certifier 29c. License number OCME 29d. Date signed (Month, Day, Year) 2 May 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin RUBIO 111 Penn Street, Baltimore, Maryland 21201 ,MO 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

Registrar

DHMH 17 Rev 1/2001

State

**ORIGINAL** 

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			1 = For State Registrar	,		rtificate of De			eg. No. 2001	15988
	Dharatat		1. Decedent's Name (First, Middle, Last)			1 1 1		2. Date of Dea Month	th Day Year	3. Time of Death
La,	Physici /Medio		VIRGINIA	Poll	ock			May	17 200	11 0 11
1	Examin	er	4a. Facility Name (If not institution, give s 184 Acton Road	street and number)		4b. City, Town, or Lo	ocation of Death	7	4c. County of Dea	th
			5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	Annapoli	LS Under 24 Hrs.	8. Date of Birth	Anne Ar	
Н	Funeral Director			M 20XF 8	• • • • • • • • • • • • • • • • • • • •		Hours Min.	Sept. 1	Year) C	thplace (State or Foreign ountry) ryland
	<u> </u>		Usual Residence of Decedent					зерс. 1.	7,1717 Ha	ryrand
	anylan show		10a. State 10b. County		ty, Town or Lo	cation				10d. Inside City Limits
	88e-f	ecto	MD Anne Ar	runde1	Annapo			<del></del>		1 ☐ Yes ANNo
	with ti	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	leath	eral	184 Acton Road	12. Was Decedent Ever in U	IS 13 V	21401		cify Ves or No-	USA 14. Race - Am	prican Indian
<b>'</b> 0	r Iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No		Was Decedent of Hispa f Yes, specify Cuban, I		Rican, etc.)	Black, Whi	
8	72 hours after death with the Maryland Ineturel', or Items 23a or 28e-f show Gical Examiner must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠No S	Specify:		Specify:	White
5-0	72 h 'netu dical	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	tent's Usual Occupatio kind of work done duri OO NOT use retired)	n ing most of workir	na	16b. Kind of Business	/Industry
121	within ene. than "	μ	Elementary/Secondary (0-12)	College (1-4or 5+)						. 1 7 1
d 2	filled h Hygie Sther	ပိ	17. Father's Name (First, Middle, Last)		OILIC	e Manager	I. Mother's Name		ledical-Dei Maiden Sumame)	ntal Exch.
an	id be lental ked c	To Be	John Anderson Moo	dv				leta Sta	,	
Maryland 21215-0036	and M s mar	_	19a. informant's Name/Relationship (Typ	-	19b. Mailin	g Address (Street and				Zip Code)
	and 2 salth a n 27 I		Harrison A. Pollo		_	Acton Road	, Annapo	lis, MI	21401	
Baltimore,	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortent: If item 27 Is marked other than "neturel", or Items 23a or 28e-f show injury or other traumatic event, the Madical Examiner must be notified at 9.		20a. Method of Disposition  1XXBurial 2 □ Cremation 3 □ R		Place of Dispo- cemetery, cren	sition (Name of natory or other place)	D	ate	20c. Location - City or	Town, State
ţ	t. Pag tmen tent; tent;		' 4 ☐ Donation 5 ☐ Other (Specify)	H		t Cemetery		2004	Annapolis,	MD
Bal	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Liftense	90		. Name and Address o Ḥardesty F	uneral F	lome, P.	Α.	
			23a, Part 1, Enter the disease, or compli	cations that caused the dea		12 Kidgely	Avenue	_Annapc	lis, MD 21	401 Approximate
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final			1			,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	NESTRICTI		LONG	DISEA	シド		4 years
	Examiner		Conventially list conditions	HYPERCA						ZYEARS
	ק יי	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	juence of):		1			,
	and and rtrans	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consec	LDEC	endavy.	to sec	ond ha	nd smoke	5 YEARS
760,	ate be executed hysician and he burial-transit	cal E		Due to (or as a consec	derice oi).	7				
687	ficate p physis the		<b>\</b> d							
Вох	n certi	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of del	iverv
W	death	icla	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	at the	Physiclan/Med	9 🗆 Unknown		22					
s,	uires that the death certifica signed by the attending ph d be detached for use as th	þ	Part II. Other significant conditions con			derlying cause given in The wlosis	n Part I.		acco use contribute to s 2 □ No 3 2 Pr	
Vital Records,	w requir been si should	Completed	\	12.	-		-	· · ·		obably 4 Unknown
Rec	sicien: The law s certificate has k lirector, page 2 s	mp	Tower of Dieed	, Diabetes	> + 101	monary.	<del></del>	24a. Was ar autops perforn	prior to	topsy findings available completion of cause of
ā	ificate or, pa	မ င်	25. Was case referred to medical	1			Diagonal Doorth	1 ☐ Yes 2	X No 1 ☐ Yes	2 No
<u> </u>	ysicie is cert direct	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	0.1	i. Place of Death 4 ☐ Nursing Hom	1 St. 50	nce 6 ⊡Other (Spec	rifu)
0	ding Phys		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			w injury occurred	ony)
Sio	eath. or: Al	atic	2 Accident investigation		,,		2 🗆 No			
Division of	after death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre y)	et, factory, office	2	3f. Location (Str City or Town	eet and Number or Ru State)	ral Route Number,
J	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledne death	occurred at the time	tate and place as	ad due to the	uco/c) and ma	stated
	e Hos 24 h e Fur letely	edical	(Check only 2 Medical Examinone)	ier: On the basis of examina and manner stated.	tion and/or inv	estigation, in my opinio	on, death occurre	at the time, da	te and place, and due	to the cause(s)
	To the Hospitel within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier	· C 1		29c. License nu	mber	29	d. Date signed (Montl	n. Day, Year)
	.(		/ /atturall	Linkavix	m	D3	3450	/	May 12,	2004
	h		30. Name and address of person who cor	mpleted cause of death (I) in	1 23a) (Type, F	Print)	1 1	. 1	1.	2004 MD 21401
	-01		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture &	remons Isla	and K	d M	napolis,1	117
	Sta Registr	-	MAY 1 9 2004	May B	Spark					

			1 = For State Registrar	State of Marylar		ent of Healt ate of Dea			ene . No. 200	L 15989
- Complete	Physici /Medic		1. Decedent's Name (First, Middle, Las	· Rohins	SOU			2. Date of Death	370 4 Yeer	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Millennium He	a street and number)	6 Center 46.0	ity, Town, or Local	tion of Death		4c. County of Dea	th
	Funeral Director		130-14.3190	ex 7. Age (In yrs.	Yrs. If Un-		nder 24 Hrs. urs Min.	8. Dete of Birth	9. Bi	thplace (State or Foreign ountry) IKGIN IA
Aaryland	show at all	ō	Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Location	MORE				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the A	le or 28a- Le notifi	Direct	10e. Street and Number	ET Ave.	~	Zip Code	1215	100	g. Citizen of What C	ountry?
:1215-0036 within 72 hours after death with the Maryland	il, or items 23 versions mus	by Funeral Director	11. Marital Status  1 Norver Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 2 WNo If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic pecify Cuban, Me: s 2 No Spe	c Origin? (Spo xican, Puerto ecify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian, te, etc. LACK
<b>21215-0036</b> bd within 72 hours at	Department of Health and Mentai Hygiene. mportant: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, Its Medical Examiner coust Let colling at 20cg.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	ducation	16a. Decedent's U (Give kind of life. DO NO	work done during	most of work	ing 16	Sb. Kind of Business	TRV
면 <sup>플</sup>	Mentai Hygia arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) UNKNIN			18. N	Nother's Name	e (First, Middle, Ma AVDE	CLARKE	
_	Health and N om 27 is ma other trauma		19a. Informant's Name/Relationship (	Type, Print) NIECE	19b. Mailing Add	ss (Street and Nu ICHWOOL	Are	ALTO	City or Town, State,	Zip Code) - 1212
ore les 1	ient of He nt: If itera iry or oth		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	Place of Disposition (/cemetery, crematory)	Name of or other place) EMEJ bly			ACTIMORE	11.
Balti permit.	Department Important: I any injury o		21. Signature of Funeral Service Licen	See	22. Name	and Address of F	ROAD	BALTI	GREENE MALE MA	
Ex	bysician and Medical caminer transit sthe private transit street	cal Examiner	23a. Part1. Enter the disease, of components of the components of	a	diac an juence of:	rythem	11 07			Approximate Interval Between Onset and Death 3 c minute 5 4 3
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed	been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	al death 3 Ectopic	pregnancy (specify)			23d. Date of de Month	livery Day Year
ds, P.	signed by d be detac	þ	Part II. Other significant conditions of	ontributing to death but not res		g cause given in P	Part I.			o the cause of death?
Division of Vital Records,	cate has been , page 2 shoul	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vita sician	certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:				(Check only one)	- 1_0	
Vision of Attending Phys	ath. nr: After this certificate has he funeral director, page 2	ation; To	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?		me 5 ∐ Residen 28d. Describe how	ce 6 Other (Spe	cify)
Divis tel or Atte	within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact fy)	tory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
Div the Hospitel or	n 24 hours a ne Funeral I oletely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exem	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, dat ion, in my opinion,	te and place, death occurr	and due to the cau ed at the time, date	se(s) and manner as a and place, and du	s stated. e to the cause(s)
To the	To the	Me	29b. Signature and title of certifier			29c. License numb	ber 444	290	. Date signed (Moni	
			30. Name and address of person who							
	Ě		31. Date filed (Month, Day, Year)	32. Registrar's Signa		2 Bal	hmore	y am	1228	
	Sta Registr	-	MAV 1 0 3001	32. Registrar's Signa	4 /					

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			For State Registrar				tificate of				004	15	990
	Physicia	an	1. Decedent's Name (First, Middle, La						2. Date of De Month	Day	Year		of Death
>	/Medic Examin	al	Helen B. Rei  4a. Facility Name (If not institution, giv		er)		4b. City, Town, o	or Location of Dea	May		2004 ty of Death	12:0	э р
	Examin	er	Greater Baltimore			er	Tows			Balt	imore	9	
	Funeral		Social Security Number     6. S		Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year)	Cou	ntry)	e or Foreign
	Director		213-38-5570 Usual Residence of Decedent		98				reu.9	, 1900	Mary.	raiiu	
	nylanc show		10a. State 10b. County			ty, Town or Lo						10d. Inside	
	he Ma 28a-1s	Director	Maryland Baltimo	re	1:	imoniun	10f. Zip Code			10g. Citizen of	What Cou		es X No
	3a or		108 Farview Cou	ırt.			2109	3		USA		ind y i	
	death	Funeral	11. Marital Status	12. Was Decede		I.S. 13.	Was Decedent of I		Specify Yes or No to Rican, etc.)			ican Indian,	
9	or Ita	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 [	No.		1 ☐ Yes 2 ☑ No			Spec	ify:		
1215-0036	filed within 72 hours after death with the Maryland Hyljoen. Niher than "natural", or Itams 23a or 28a-f show ent, Ita Mazikal Exzeriment he nodified at	ed b	15. Decedent's E	Year or Date	<b>5</b> .					16b. Kind of I		Uhite ndustry	
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72	be filed within 72 ho ltal Hygiene. d other than "natur event, the Madical	Con	17. Father's Name (First, Middle, Last,	<del>_</del>		Scho	ool Teach		me (First, Middle	Baltimo		ounty	20,000
_	od la de S	To Be	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	iyce				Min		Mari			
ary	W - m -	-	19a. Informant's Name/Relationship (	<u> </u>		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb			p Code)	
	1 and 2 Health a lem 27 Is		Don Reier / Son		1001		arview C	ourt T	imonium,				
Baltimore,	8°= 5		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □		te	cemetery, crei	sition (Name of matory or other pla	1 .		20c. Location			1
	permit. Pag Department Important: any injury once.		' 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licenta	1	טט.		/alley Ce		/ 114	Timoniu 1050		aryıar k Road	
Ba	permit. Departr Importa		Carl J.	ang	7	Ruc	ck Towsor	n Funeral	. Home.	Inc.Tows	son,M	d.2120	J4
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	sed the dear	th. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	arrest,		Approxim Interval B Onset an	Between
9	Physician		Immediate Cause (Final disease or condition resulting in death)	a Car	dia	cac	rest					MINN	
	/Medical Examiner		Tooling in acamy	Due to (or	as a consec	quence of):	rest tery o	1:0003	i e			6 40	2ars
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	acuted ind transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c									
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687	ficate g phys		`	d									
ŏ	ih cert ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnanc	v		1	ate of deliv	•	
Division of Vital Records, P.O. Box	w requires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnan 9□Unknow	t at time of d		Other (specify)			M	lonth	Day	Year
<u>a</u> .	that the ed by detacl	/ Ph	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use cor	ntribute to	the cause o	f death?
rds,	n sign	d b	Diabetes m	ellitu	s, ac	lu1+	onset		10	Yes 2000	3□ Pro	bably 4	∐Unknown
000	aw receist bee	plete	Hyperten si	0~					24a. Was		Were aut	opsy finding	s available
ř	The tate he page	Com	-/1						perfe 1 ☐ Yes	ormed? 2 No	death? 1 🗌 Yes	_	
Vita Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		<b>7</b> -00	Ot	205	ath (Check only				
ō	Phys er this eral dii	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of I	njury	ER/Outpatier 28b. Time o	f 28c. Inju	ry at	Home 5 ☐ Res 28d. Describe	how injury occu		(fy)	
0	ath. r: Afte	atio	1 Natural 5 Pending 2 Accident investigatio	n	Day Year)	Injury		rk? ]Yes 2∐No					
<u>X</u>	after de Directo	Certification:	3 Suicide 6 Could not be determined	Zoe. Place of	Injury - At h etc. <i>(Speci</i>	iome, farm, sti fy)	reet, factory, office			(Street and Num iwn, State)	ber or Rur	al Route Nu	ımber,
	ospital hours a uneral E		29a. Certifier 12 Certifying Pl	nysician: To the be	est of my kn	owledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause(s) and n	nanner as s	stated.	
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical		miner: On the basi and manner	s of examina								)(s)
	To the Ho within 24 I To the Fu completely	Ž	29b. Signature and title of certifier	000	MI	)	29c. Licen			29d. Date sign	ed (Month,	Day, Year)	
."	M		(anol/	ewill	11 4		D4	7 / 1 /		5/18	10	7	
			Carol Newill, MD	7801 Y	or death (Ite	m 23a) (Type.	WSON N	10 212	204				
	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Sign	ature	wson n						
	Regist	rar	MAY 1 9 2004	MORE	, so	A CONTRACTOR OF THE PARTY OF TH							

			1_ For		aryland / C	epartment of	Health and I	-	_	
			Registrar			Certificate of	Death		Reg. No. 🚄 🔾	104 1599
	Physic /Medi	cal	Decedent's Name (First, Middle, Last     Helen	,	1	Reed		2. Date of De	ath Day 13.2	3. Time of Death
	Exami	ner	4a. Facility Name (If not institution, give	street and number)	11	4b. City, Town,	or Location of Death	- 11	4c. County	of Death
			Maryland Go	neral t	tespita	in paltic	nove (	1+1	NA.	
	Funeral Director		214-50-6488	7. Age □ M 2 X F 5	(In yrs. Yast birt	hday) If Under 1 Year Months Days		8. Date of Bin (Month, Da 9-5-4		Birthplece (State or Foreign Country)  Md
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Mary	Director	Md. NA			timore				X□Yes 2□No
	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	ath v 23e		833 Seagull Ave.	Apt. B		2122			USA	
	er de	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-	- 14. Raci	e - American Indian, ck, White, etc.
21215-0036	4 within 72 hours after death with the Maryland jiene rithen "natural", or Itams 23e or 28e-f ehow the Modicel Examiner must be rotified at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Oates:	0	1 ☐ Yes 2√2 No			Specify	
15-(	"natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of work	ing	16b. Kind of Bu	usiness/Industry
12	within ene. then "	d m	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use retire L'eacher's A			Paltimo	School ore City Public
	Hyger H		pth grade 17. Father's Name (First, Middle, Last)			reacher 5 A	18. Mother's Nam	e (First, Middle.		
lan	d ta b	To Be	Edward		Taylor		Marie	,,		Smith
Maryland	S P E E	-	19a. Informant's Name/Relationship (T)			Mailing Address (Street		al Route Numbe	r, City or Town,	
	and 2 lealth a m 27 is		Beverly Taylor	Niece		942 Cherryl				21225
altimore,	es 1 a of Hez fitem r othe	1	20a. Method of Disposition	2	20b. Place of cemeter	Disposition (Name of crematory or other pla	ice)	Date	20c. Location -	City or Town, State
Ĕ	Pages ment of i ent: If its ury or o		†☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		est Cem.	- !	0-04	Harmon	s, Md.
a T	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licens	600		22. Name and Addre	ess of Facility	Baltin	nore, Md	
<u> </u>	20 E # 9	V (	23a. Part1. Enter the disease, or compl	Wani		March F.			. North	Ave.
X	Physician /Medical Examiner parish transit	Examiner	shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Uue to (or as a	consequence o	ir enia	overnt	Sulas		Interval Between Onset and Death
8760	ate be hysici	lical		d						
P.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	: Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date Mon	a of delivery tth Day Year
	that t	h H	Part II. Other significant conditions cor	ntributing to death but	not resulting in	the underlying cause give	ven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
rds,	puires than signed lad be det	D	> xogenous	Obesit	1					3 Probably 4 Unknown
Ö	w requir s been si should	iete	Dichotes 1	10/11/all	C			24a. Was a	0 24h W	Vere autopsy findings available
Vital Record	: The law requires that the cate has been signed by th page 2 should be detache	Сош						autops	med? de	rior to completion of cause of eath
<u> </u>	ician certifi ector	Be	25. Was case referred to medical examiner?	lospital:		l ou	26. Place of Deatl	(Check only or	10)	
ot	Phys this ral din	2	1 Yes 2 No	28a. Date of Injury			4 U Nursing Ho			
on	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		ury Wo	rk?  Yes 2□No	200. Describe in	ow injury occurre	90
Division of	I or Attending Physician: after death. Director: After this certification by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farr (Specify)	n, street, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	or or Rural Route Number,
נ	Hospita 4 hours Funerell ely fillec	edicai Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of e and manner state	examination and	death occurred at the tile for investigation, in my c	me, date and place, opinion, death occurr	and due to the c	ause(s) and man ate and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date i igned	(Mo th, Day, Year)
	- > - 0						51945		5/11	MIL
	A		30. Name and address of person who co	empleted cause of dea	ath (Item 23a) (T	ype, Print)	2017	>	1110	7
	12		James Tans	nda Mi	0 401	Varylan	d Gen	eral	406	pital
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Angel is	en			

			For State Registrar		State of Ma	aryland / De	epartm Certific	ent of H ate of L	lealth and N Death	Mental Hy	ygiene Reg. No		04	15992
	Physici /Medio		1. Decedent's Name (A		0)	Rollin				2. Date of D Month May		3, 2	004	3. Time of Death 5:30 p M
,	Examir Funeral Director		4a. Fecility Name (If not 18801 Walk 5. Social Security Num 219-54-696 Usual Residence of De	ers Choi	ce Road	e (In yrs. last birtho 88 Yr:	day) If Ur	Saithe	rsburg If Under 24 Hrs. Hours Min.	8. Date of B (Month, C Aug 13	irth Day, Yeer)	9	tgom	ece (State or Foreign
	72 hours after death with the Maryland natural', or tems 23a or 28e-f ehow disal Examulae must be mailliad at	ector	MD 10a. State 10	ob. County Montgome	ery	10c. City, Town of	ersbu	3			1			od. Inside City Limits  1 ☐ Yes 2 ☐ No  XX
	ath with the 23a or 2	ral Dir	10e. Street and Number					Zip Code 20886			U	S.A.		
036	ours after de al', or items Examinativ	by Fune	11. Marital Status 1 ☐ Never Married 3 ◯ Widowed 4 [		12. Was Decedent Armed Forces? 1 ☐ Yes ② ↑ If Yes, Give Year or Dates:	Ever in U.S.		cedent of Hispecify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	lo-	14. Race - Black, Specify:	White, e	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f ehow any rightry or other traumatic event. It makedical Evertime must be notified at ance.	Completed by Funeral Director	15 (Specify Elementary/Seconda Grade 12	5. Decedent's Edi only highest grad ary (0-12)	ucation de <i>completed)</i> College (1-4or 5	(C li	give kind of	Tuse retired	furing most of work	ing		ind of Busin		ustry
	id be filed ental Hyg ked othe ic event.	To Be C	17. Father's Name (Fir Roy Sample	st, Middle, Last)		,			18. Mother's Name		e, Maiden	Sumame)		
Maryland	und 2 shou alth and M 27 Is mar or traumat		19a. Informant's Name Valerie Ha		ype, Print) daught				and Number or Run Choice F					Code) D 20886
Baltimore,	Pages 1 and of He ant: If item ury or other		20a. Method of Dispos 1 X Kurial 2 C 4 Conation 5 (	Cremation 3 □	Removal from State	20b. Place of D cemetery, Lakemont	crematory (	or other place	θ)	Date 7/2004		idson		
Balt	permit. Departr Imports any inj		21. Signature of Funer	ral Service Licens	/	M00770			ศินกิชฟัลl E t Avenue			arylaı	nd	20707
	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart fa Immediete Cause (Fin disease or condition resulting in death)	ailure. List only o	a. Conges  Due to (or as	ne. tive Hear a consequence of)	t Fai	lure	g, such as cardiac	or respiratory a	arrest,			Approximate Interval Between Onset and Death 17 months
68760,	icate be executed physician and s the burial-transit	edical Examiner	f any, leading to immer cause. Enter Underlyi Cause (Disease or inju- that initiated events resulting in death) Las	ediate ing ury	Due to (or as	ry Artery a consequence of): a consequence of):		ase						15 years
O. Box (	Physician: The law requires that the death certific this certificate has been signed by the attending prat director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 Yes 2 PN 9 Unknown	egnani	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 Ectopie 5 Other					23d. Date o Month		y Day Year
٥.	quires that en signed b	þ	Part II. Other significa Atrial Fibr					g cause give	on in Part I.		tobacco u			e cause of death?
al Reco	: The law recate has been cate has been cate has been cate has been cate has been categorians.	Completed									s an opsy ormed? 2 \dagged\dagged\dagged	prio	r to com	sy findings available pletion of cause of
Division of Vital Records,	Jing Alte fune	atlon: To Be	25. Was case referred examiner?  1 ☐ Yes 2 ☐ You  27. Manner of Death  1 ☑ Yatural  2 ☐ Accident	110	Hospital: 1 Inpatie 28a. Date of Injui (Month, Da)	nt 2 ER/Outpa y 28b. Tim 'Yeer) Inju	e of	DOA Othe 28c. Injury Work 1 🗆 Y	4   Nursing Ho		idence		(Specify)	
Divis	tel or Attan s after deat el Diractor: ed in by the	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm c. (Specify)	, street, fac	ory, office		28f. Location ( City or To			or Rural	Route Number,
	To the Hospitel or Attant within 24 hours after deat! To the Funerel Diractor: completely filled in by the	Medical	one) 2	_ Medical Exem	sicien: To the best of iner: On the basis of and manner sta	examination and/o	rinvestigat	on, in my op	inion, death occurr	and due to the ed at the time,	, date and	i place, and	due to t	he cause(s)
	S D With	2	29b. Signature and TN	deline	_MO			29c. License D 22				te signed ( $^{\prime\prime}$		
_	10		30. Name and address Christine			eath (Item 23a) (Ty 520 Van D		Road #	260 Lau	rel, Ma			2070	
	Sta Registr		31. Date filed (Month, MAY 1	9 2004	32. Registra	r's Signature	don	161	·					

04-3270 B.K.S

Unpend item#23a,Part II,27,PFR ME,G833,7/26/04eg

C.S			Please Type or Print in Black	•	-
ÆS	ROBERT	s .	_ FOI	partment of Health and Mental ertificate of Death	Reg. No. 2004   5995
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	h Day Year
1	/Medic	al .	James A. Roberts	MAY	14, 2004 0950 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number) 5214 BEAUFORT AVENUE	4b. City, Town, or Location of Death BALTIMORE CITY	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdomic 1216-42-6193 12 M 2 F 60 Yrs	Months   Days   Hours   Min.   (Month	of Birth h, Day, Year) 9. Birthplace (State or Foreign Country) Maryland
,	and **		Usuel Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location	10d. Inside City Limits
	the Marylar 28a-f show	ctor	MD NA	Baltimore	1 X Yes 2 □ No
	diff th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23e	ral	5214 Beauford Avenue  11 Marital Status 12. Was Decedent Ever in U.S. 1	21215	USA or No- 14. Race - American Indian.
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.  The teath and Mental Hygiene.  Other treumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. ☐ Yes 2. ☐ No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc)</li> <li>Yes 22 No Specify:</li> </ol>	Black, White, etc.  Specify: Black
9	2 hou	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation ive kind of working	16b. Kind of Business/Industry
121	should be filed within 7:  Id Menial Hygiene.  marked other than "n  imatic event, the Medi	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	ive king of work gone during most of working e. DO NOT use retired) ver Worked	NA
	filled Hygid Sther ant, II		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
Maryland	id be ental ked c	To Be	Cranford Caldwell	Elizabeth Ro	berts
ary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type, Print) 19b. M.	ailing Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
	and 2 salth a n 27 ts			33 Ednor Road Baltimore,	MD 21215
ore	of He of He fitten r oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition	sposition (Name of Crematory or other place)	20c. Location - City or Town, State
Ĕ	Pag ment ent:1 ury o		'4 □Donation 5 □Other (Specify) Cedar H:	ill Cemetery 05-19-04	Glen Burnie, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 it any injury or other tre		21. Signatur of Funeral Service Licensee	22. Name and Address of Facility Wylie Funeral Home 638 N	J.Gilmor St. Balto, MD212
	Medical Examiner	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Arteriosclerotic Card  a.  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):	iovascular Disease	Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medi		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
ds, P	uires that signed to lid be deta	d by PI	Part II. Other significant conditions contributing to death but not resulting in the HIstory of Seizures, Schizophrenia		Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	sicien: The law req certificate has beer irector, page 2 shou	omplete			Was an autopsy findings available prior by completion of cause of death?  Yes 2 □ No 1 ✓ Yes 2 □ No
ital		Be C	25. Was case referred to medical	26. Place of Death (Check of	
f V	Physic this ce al direc	70	examiner?  1 X Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing Home 5	Residence 6XX6ther (Specify) AT SCENE
0	ding PI n. After th funeral		27. Manner of Death 1 ▼ Natural 5 □ Pending  28a. Date of Injury (Month, Day Year)  Injur	y Work?	cribe how injury occurred
Sio	uttendi death. ctor: A y the fu	catl	2 Accident investigation	M 1 Yes 2 No	ing (Channel Warter Specification)
Division	or At after Direc in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		ion (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, do 2 Medical Exeminer: On the basis of examination and/o and manner stated.		
)	To the vithin To the comple	Me	29b. Signature and title of certifier.	29c. License number O.C.M.E	29d. Date signed (Month, Day, Year) MAY 15, 2004
				nn Street, Baltimore, Ma	aryland 21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	AL D	
	Registr	ar	MAY 1 9 2004		

			1 - For State Registrar		aryland / Dep <i>Ce</i>		t of H	ealth an		•	ne <sub>2001</sub>		5994
H	Physici	ian	Decedent's Name (First, Middle, Last						2. Date Mor	e of Death	Day Yea		ne of Death
4	/Medi	cat	Kathryn A. Stutzm			44 67			May	7 10	6 2004		48 a <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give  3 Bristol Hill Co					Location of D			4c. County of De		
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under		ISVIIIE If Under 24	Hrs. 8 Date	e of Birth	9.9	imore	ate or Foreign
	Director		Usual Residence of Decedent	] M 2[XF	86 Yrs.	Months	Days	Hours A	June	nth. Dav. Yea	1917 Per	country) insylva	ate or Foreign ania
	s within 72 hours after death with the Maryland Jiene. r then "natural", or items 23a or 28a-f ehow the Medical Examinat must be tootified at	7	10a. State 10b. County  Maryland Baltimor	æ	10c. City, Town or Lo								le City Limits Yes 2 ∏No
	the N	Funeral Director	10e. Street and Number		- Catcons	10f. Zip	Code			100	Citizen of What		X140
	3a or	0	3 Bristol Hill Cou	irt A_4			228			109.1			
	death	nere	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.			spanic Origin?	? (Specify Yes uerto Rican, e	s or No-	United 14. Race - An	nerican India	
9	after or ite	/Fu	1 XNever Married 2 ☐ Married	1 ☐ Yes 2 🔀 N If Yes, Give	0	irres,sped 1⊡ Yes 2			uerto Rican, e	etc.)	Black, Wi		
Maryland 21215-0036	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:							Specify: W		
15-	C 2 08	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	dent's Usua kind of wor DO NOT us	k done d	uring most of	working	16b.	Kind of Busines	ss/Industry	
212	filed within I Hygiene. other then "ent, the Me.	omp	Elementary/Secondary (0-12)	College (1-4or 5-	+) """.		lerk				City Gov	ernmor	·+
ğ	Hyger Hyger	Be C	17. Father's Name (First, Middle, Last)				Teck		Name (First, I			erimei	IL.
ılar		To B	John J. Stutzman					Eli	zabeth	M Co	rnhardt		
lan	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Ty	рө, Print)	19b. Mailii	ng Address	(Street a	nd Number or	Rural Route	Number, City	or Town, State,	, Zip Code)	
	es 1 and 2 should of Health and Mer f Item 27 is marker r other treumatic		Gloria D. Kornman	/ Niece	1103 20b. Place of Dispo	Wisco	nsir	Avenu	e, Lyn	nhaven	, Flori	da 324	44
Baltimore,			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	lemoval from State	Cernetery, Crei	nationy of ot	ner place	"					
Ë	t. Pa rtmen rtent: njury		'4 □Donation 5 □Other (Specify)		Woodlawn			5/	/20/200	)4 Ba	ltimore,	Mary.	Land
Bal	permit. Page Department of Importent: If any injury or ance.		21. lignatur of Funeral Service License	20.0	22	. Name and	d Addres	s of Facility	Hubbard	d Fune	ral Home	e, Inc	
			23a. Part1. Enter the disease, or compli	cations that caused	the death. Do not ent	107 W er the mode	ilke	ns Ave	nue, B	altimo	re, Mar	yland Approxi	
	Discripton.		shock, or heart failure. List only or Immediate Cause (Final	16 cause on each line	9.		, ,	,,		,,		Interval	Between and Death
	rnysician /Medical		disease or condition resulting in death)		tory Failu	re						3 day	S
В	Examiner				Emphysema							30 y	0020
	P ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):							30 y	ears
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
8760,	icate be executed physician and s the burial-transit	E E	1630tting in death) East	Due to (or as a	consequence of);								
387	physics the b	dlcal		· <del> </del>									
9 x c	law requires that the death certificas been signed by the attending place should be detached for use as to should be detached for use as the second of the second because the second of	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o	f pregnancy						23d Date of de	discor	
Вох	death a atter d for u	clar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	! ☐ Fetal death 3 ☐	Ectopic pre					23d. Date of de Month	Day	Year
Ö.	res that the de signed by the a be detached t	hys	9 Unknown	9□ Unknown									
S,	ss tha gned se det	by P	Part II. Other significant conditions con	tributing to death bu	not resulting in the ur	nderlying ca	use give	n in Part I.	23e.	. Did tobacco	use contribute (	to the cause	of death?
ord	w require been signature	ted	Coronary Heart Dis	ease. Aty	pical				_	1 ☐ Yes	2 <b>√</b> No 3□P	robably 4	□Unknown
Records,		Completed	Mycobacterium Infe	ction both	n lungs				24a.	. Was an autopsy	24b. Were a	utopsy findin	
	Th ate pag	Con	Bronchioctasis.	Pulmonarv	Fibrosis				1 🗆	performed? Yes 2 XN	death?		
Vital	ilcien: Th certificate ector, paç	Be	25. Was case referred to medical examiner?	ospital:					Death Check	onl one)			
ot	Phys this ral dir	£.	1 Yes 2 No	1 ☐ Inpatien 28a. Date of Injury	t 2 ER/Outpatien			- I radi siriç			6 ☐ Other (Spe	ecify)	
	ding Phy th. After thi funeral	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	M	C. Injury Work	es 2 No	280. Desi	cribe how inj	ury occurred		
Division	il or Attending Physicien: after death. Director: After this certifica d in by the funeral director,	ifica	3 ☐ Suicide 6 ☐ Could not be		y - At home, farm, stre	_			28f. Local	tion (Street a	and Number or R	lural Route N	lumber.
ā	afte Dir	Certification:	4  Homicide determined	building, etc.	(Specify)				City	or Town, Sta	te)		
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (	29a. Certifier 17 Certifying Phys (Check only 2 Medical Examin	ier: On the basis of e	my knowledge, death examination and/or inv	occurred a estigation,	t the time	e, date and pla nion, death oc	ace, and due to	time, date ar	s) and manner a	s stated.	e(s)
	o the ithin a o the	Med	29b. Signature and title of certifier			00-	17				ate signed (Mon		
	F ≯ F 8		1-00 max	) ATTEN	Wing Phys	ICAN	01620	00					,
	10		30. Name and address of person who co							Ма	y 18,	2004	
	4)		Dr. N.M. Machiran		den Choice		, C-	tonari	170 м	[	A 21220		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	المستحدث	, .	LVESVI	TTE, M	<del>ar y ia</del> n	u 21228		-
	Registra	ar	MAY 1 9 2004	Con .	A AMERICA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SHEPHALI ANNA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** KONTHINEST CENTER RANDAUSTONN BALTIMORE HSSAITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Jan 13, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Director 70 1934 216-28-7076 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 7300 Casamoor Road 21244 United States Funeral Itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No ģ Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is markad othar than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward N. Riley Ella Mae Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Riddle / Daughter 1435 Claridge Avenue, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State injury 4 □ Donation 5 □ Other (Specify) 5/19/2004 Marriottsville, MD Crest Lawn Gardens 22. Name and Address of Facility Hubbard Funeral Home, 21. Signature of Funeral Service 4107 Wilkens Avenue, Baltimore, Maryland 21229 any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHROVIC OBSTRUCTIVE LUNG SOVENE Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -transit and Due to (or as a consequence of): attending physician a for use as the burlal-Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□ Pregnant at time of death 5 Other (specify) detached Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ WITH SHEEL Center 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 1 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 patient 2 ER/Outpatient 2 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funaral Diractor: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) MAY 16, 2004

DHMH 17 Rev 1/2001

Registrar

BRIANDO 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - CONANAN,

2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year SCHLINE WILLIAM Η. MAY 14 /Medical 2004 3:55 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE TOWSON

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. BALTIMORE CO. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ 2□F Months 88 Yrs. **Director** 215-05-6287 Nov.01 1915 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f ehow the Medical Examinational Le notified at Director 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3930 Brooklyn Ave. 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 → Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Be Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Electrician/Supervisor Chemical Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H 0 William Η. Schline Sr. Charlotte Denz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is m any injury or other treum QDG. 3930 Brooklyn Ave. Baltimore, Md. 21225 Evelyn I. Schline (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cedar Hill Cemetery | 05/18/2004 Baltimore, Md. 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee m00922 237 E. Patapsco Ave. Baltimore, Md. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** se 5 y n drome ses disease or condition resulting in death) weeks /Medical Due to (or as a consequence of): Examiner neumani wells Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 plonths?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, myocardial farct ion 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 Yes 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 125205 30. Name and address of person who completed causandeath (Item 23a) (Type, Print)
W. A. R. (ey GBMC 6701 N. Cl ules St. Balto md 2120x N. Ch 32. Registrar's Signature 31. Date filed (Month, Day, Year) 9 2004 Registrar

DHMH 17 Rev 1/2001

Last

May

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A. S.	/Medic		DORIS J. SMITH  4a Fecility Neme (If not institution, give street end number)  4b. City, Town, or Lo								h 4c. Cou	nty of Death	(103 111	-		
1	Examin	er		ARE-RUXI					TOW			BALTIMO	ORF.			
	Funeral Director	9	5. Social Security N 218-14-5		Sex 1□M 2□xF	7. Age (In yrs. lest birthdey) If Under 1			r If Under 24 H	rs. 8. Date of Bi	1			n		
Baltimore, Maryland 21215-0020	land m		Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location									1	0d. Inside City Limits	_		
	Mary n-f sh	to	MD BALTIMORE PARKVILLE									1 □ Yes 2√□ No	,			
	or 28	i e	10e. Street end Nur	mber				10f. Zip Code			10g. Citizen	of What Cour	itry?			
	138 W	<u>e</u>	1826 RED	21234						USA						
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, i're Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Marri  3 ☐ Widowed	Armed Fo	1 ☐ Yes 2 🔀 No			as Decedent of Hispanic Origin? (Specify Yes or Ness, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 ☒ No Specify:			14. Race - American Indian, Black, White, etc.  Specify: WHITE					
	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Say in the 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seco		ede completed)	ation completed) Cotlege (1-4or 5+)		16e. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)  ASSEMBLER			king		of Business/Industry			
	filed Hygid After The	ပိ	12TH GRAI 17. Father's Neme		1)		ADDL	SHIDDER	18. Mother's N	ame (First, Middle		_				
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	2 should and Men la marke aumatic		19a. Informant's Na	ame/Relationship				ng Address (Stree	t and Number or I	Rurel Route Number, City or Town, State, Zip Code)						
	l and lealth m 27 her tr	1	ROBERT C. SMITH HUSBAND 1826 REDWOOD AVENUE  20a. Method of Disposition (Name of							BALTIMORE, MD 21234						
	Pages hent of H			Cremation 3		State	cemetery, cren	natory or other pla	·	Date 20c. Location - City or Town, State						
	permit. P Departme Importani any injury once.	1	4 Donation 5 Other (Specify)  METRO CREMATORY, INC. 5/19/04 CATONSVILLE, MD  21. Signature of Funeral Service Licensee													
ä	Depa Impo		21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HONE, P.A.  8521 LOCH RAVEN BLVD. TOWSON, MD 21286													
	Physician /Medical Examiner		23a. art1. Enter the shock, or head Immediate Cause (disease or condition resulting in death)	ne disease, or com nt failure. List only Final	pplicating that one cause on e	400		e In	farctio		rrest,		Approximate tnterval Between Onset and Death			
68760,	n certificate be executed anding physician and use as the burial-transit	8	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as e consequence of):  Due to (or as e consequence of):													
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Il Records, P.O.	The law requiras that tha daath certifi sta has been signed by the attanding page 2 should be datached for use as	Completed by Physician/M								24a. Was perfo	an eutopsy rmed?	ava	re autopsy findings ilable prior to appletion of cause leath?			
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Vital	ysiclan: The law iis certificata has b i director, page 2 s	- □	25. Was case referrexaminer?		26. Place of Death (Check only one)  Hospital:											
Division of \	th. After this of funeral dia	tion: To	1 ☐ Yes 2 ☐ 27. Manner of Death 1 ☐ Natural 2 ☐ Accident		28e. Dete of Injury (Month, Dey Year)  28b. Time of tnjury (Month, Dey Year)  28b. Time of tnjury 28c. Injury at Work?						ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred					
	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certifical completaly filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
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DHMH 16 Rev 6/95

			1 - For Amend Item #20a- Registrar	c Statemf	<b>M3</b> 17572	d/OP <del>Ce</del> i	rtment of	Health : f Death	and Me		giene leg. No. 2	004	15998		
	Physic	ian	Decedent's Name (First, Middle, Last)								2. Date of Death 3. Time Month Day Year				
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	Funeral		5. Social Security Number 6. S		Age (In yrs.		If Under 1 Yea	r If Under					ice (State or Foreign		
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	3e or	0	2614 Aisquith Street 21218 USA								What Ocurn	y:			
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	Maryland d 2 should be file th and Mental Hy t7 Is marked oth treumatic event		19a. Informant's Name/Relationship (7	· .		1	g Address (Stree					State, Zip C	Code)		
			Derrick Smith  20a. Method of Disposition	Son			Aisquit					21218			
	A # 0		1√2 Burial 2 ☐ Cremation 3 ☐	Removal from St			sition (Name of latory or other p		/25/04		20c. Location - Dundalk,	MD City or Tow	n, State		
:	Baltimo permit. Page Department ( Importent: If any injury or		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Gar		Forest Name and Add				Owinga				
	Bal permi Depa Impo any ii	1	Munt 6	9/					, 0		re, Md.		02		
			March F.H. East 1101 E. North Ave.  23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between												
	Physician		Immediate Cause (Final									Onset and Death			
	/Medical		disease or condition resulting in death)  a. Respiratory in Symples in the symple										Corres.		
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No.	St Bd	la e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								1	ninh			
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	I HECOrds, P.O. BOX 61 The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Catania				23d. Da	e of delivery			
(	death death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		it at time of de		Ectopic pregnan Other (specify)	cy			Мо	nth Da	ay Year		
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_	VITAI HECOTOS, P.O. sicien: The law requires that the dentificate has been signed by the rector, page 2 should be detached	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
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	D OT B Phys er this	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at							Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
#	ilon ( inding F ath. r: After re funer	atlo	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No												
-	DIVISION I or Attending after death. Director: Afte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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5	UNISION OT VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely tilled in by the funeral director.	Medical Certification;	29a. Certifier  (Check only one)  1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										ed. e cause(s)		
	To the I within 2.	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mc								(Month. Da	v. Year)			
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	6		30. Name and address of person who d		of death (Item	23a) (Type, F									
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		ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's,€igna	ture	4								
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State of Maryland / Department of Health and Mental Hygiene? [] [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Felipe Lleander Santillan 9:30 A Mau 14, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 5713 Trumps Mill Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Philippines 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1(X M 2□ F Months Days Hours Min 88 Yrs. 214-98-5826 26,1915 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5713 Trumps Mill Road 21206 U.S.A. "naturel', or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 22e any injury or other trainment. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Filipino δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mechanical Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Santillan Aniceto Justina Lleander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5713 Trumps Mill Road, Baltimore, MD 21206 Ori Natividad (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State Gardens of Faith 5/18/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lice Service 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final St **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 2010 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 053462 MD ddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Manuses ROAd Burnie MD Glen Ophwood 1 22 Regionar's Signary Registrar

State Registrar

29a. Certifier

29b. Signature

and title of certifie

Name and address of person

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

Allo

22. Registrar's Signature

and manner stated.

who completed cause of fea

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 11, 2004

111 Penn Street, Baltimore, Maryland 21201